The Report of the

Advisory Committee on Dental Care for Ontario Children

March 1987

(4)

THE REPORT

of the

ADVISORY COMMITTEE ON DENTAL CARE

for

ONTARIO CHILDREN

MARCH, 1987

February 12, 1987

The Honourable Murray Elston
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Queen's Park
Toronto, Ontario
M7A 1R3

Dear Mr. Elston:

Following your request the Advisory Committee on Dental Care for Ontario Children is pleased to submit this report. The undersigned hope this program can be implemented by the beginning of the 1987/1988 school year.

Yours sincerely,

L. W. Armstrong

W. R. Reesor

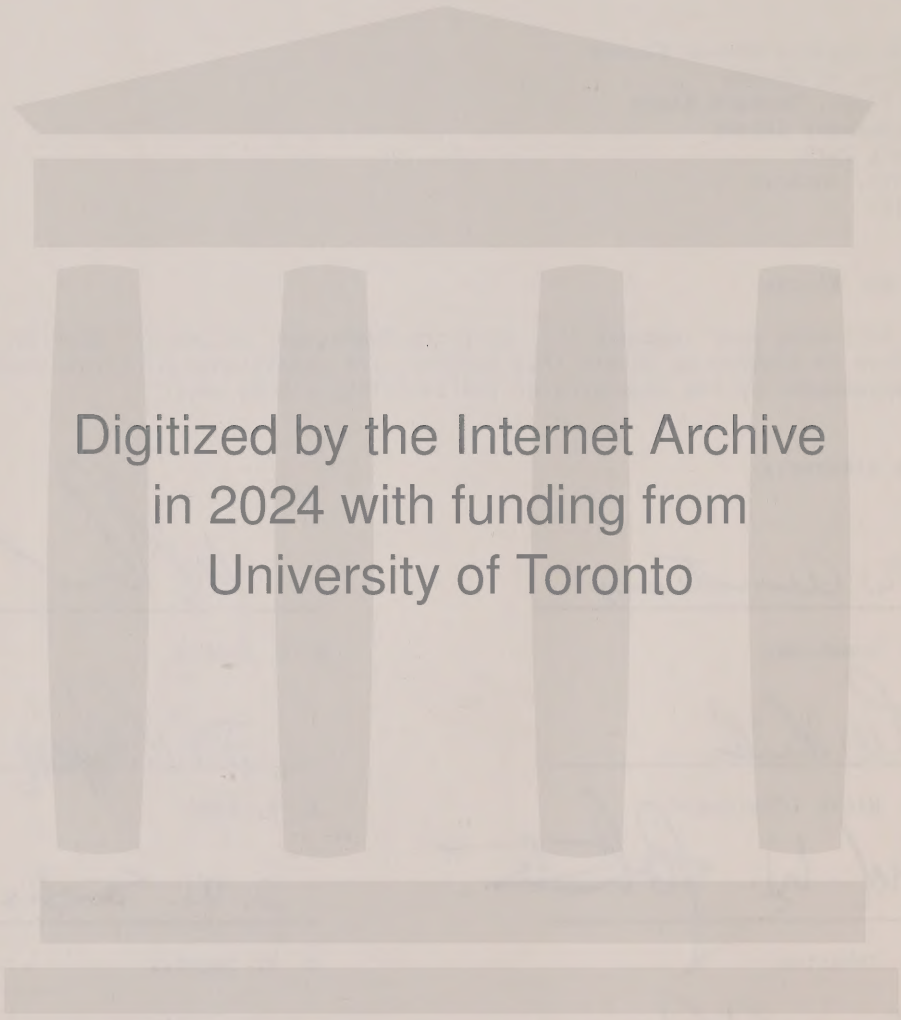
T. W. Hicks (Chairman)

R. K. Ryan

D. W. Johnston

D. W. Surplis

J. L. Leake



THE REPORT
of the
ADVISORY COMMITTEE ON DENTAL CARE
for
ONTARIO CHILDREN

MARCH, 1987

MEMBERSHIP

ADVISORY COMMITTEE ON DENTAL CARE FOR ONTARIO CHILDREN

Chairman:	Dr. T. W. Hicks, Dental Director Simcoe County District Health Unit County Administration Centre Midhurst, Ontario L0L 1X0
Members:	Dr. L.W. Armstrong, Dental Director Northwestern Health Unit 15 Ocean Avenue West R.R. # 1 Kenora, Ontario P9N 3W7
	Dr. D. W. Johnston, Chairman Division of Community Dentistry Faculty of Dentistry University of Western Ontario London, Ontario N6A 5B7
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Recording Secretary:	Mrs. D. Horsburgh, Corporate Support Officer Community and Public Health Division Ontario Ministry of Health 5th Floor, 15 Overlea Blvd. Toronto, Ontario M4H 1A9

TERMS OF REFERENCE

ADVISORY COMMITTEE ON DENTAL CARE

FOR ONTARIO CHILDREN

1. To review available information on the dental health status of Ontario children.

2. To identify priority areas in terms of groups of children or areas of the province which may most need assistance in obtaining urgently needed dental treatment services.

3. To define the basic dental treatment services which could be provided to the children identified.

4. To recommend a program to best meet the identified needs through payments to local health units and estimate initial and projected funding requirements.

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Attachments

GLOSSARY

At Risk	refers to a child with immediate or urgent dental treatment needs whose family does not have third party coverage and for whom the cost of treatment represents a financial hardship
Child and Family Services	also referred to as "Children's Aid Society"
Child Dental Neglect	a child with dental conditions which can, if not rectified, lead to a situation of a child being "in need of protection" (see attachment #1)
Child in Need of Protection	as defined in the Child and Family Services Act, "where the child has suffered harm inflicted by the person having charge of the child or caused by that person's failure to care and provide for or supervise and protect the child adequately and/or where, the child requires medical treatment to cure, prevent, or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment".
Low/Marginal Income Families.....	families without adequate financial resources to provide basic dental care for that child
MCSS	Ministry of Community and Social Services
MoH	Ministry of Health

ODA	Ontario Dental Association
OSPHD	Ontario Society of Public Health Dentists
Predetermination	a process requiring the child's dentist to seek prior authorization to provide those benefits listed in Part two of the schedule.
RCDS	Royal College of Dental Surgeons
Schedule	a Schedule of Dental Benefits outlining the services covered by the program and including instructions for its use
SMOHO	Society of Medical Officers of Health of Ontario
Social Services Agencies	also referred to as "Welfare Department"
Third Party Coverage	any form of dental benefits provided by an agency.
deft	the number of decayed, extracted and filled primary (deciduous) teeth -- a cumulative numerical history of primary tooth decay
DMFT	the number of decayed, missing and filled permanent teeth -- a cumulative numerical history of permanent tooth decay
CTR	caries treatment requirements -- a measure of the number of teeth in need of treatment as a result of dental decay
Immediate Dental Needs	includes pain, infection, haemorrhage and trauma (see also attachment #2)
Urgent Dental Needs	decay in permanent or crucial primary teeth and periodontal disease not reversible by oral hygiene (see also attachment #2)

A DENTAL TREATMENT PROGRAM FOR ONTARIO CHILDREN AT RISK

RECOMMENDATIONS

PAGE:

A DENTAL TREATMENT PROGRAM FOR ONTARIO CHILDREN AT RISK

INTRODUCTION

In the late 70's changes in the Child Welfare Act (1978) and drafts of the Health Protection and Promotion Act (1983) indicated to public health dental directors that they had a heightened responsibility in the area of child dental neglect. Recognizing the need for clarification, the Ministry of Health established a Project Team which eventually produced a document entitled "Recommended Procedures For Identifying And Reporting Suspected Child Abuse Resulting From Dental Neglect For Public Health Dental Departments". This document was revised in 1986 and is attached in amended form (Attachment #1).
The Project Team was composed of representatives from the Ontario Dental Association (ODA), the Royal College of Dental Surgeons (RCDS), the Ministry of Health (MoH), the Ministry of Community and Social Services (MCSS), the Society of Medical Officers of Health (SMOHO), and the Ontario Society of Public Health Dentists (OSPHD).

While acknowledging the appropriateness of the documents, dental directors realized that many low/marginal income families would not have the financial resources to fund even basic care. Initial discussions held with many local social service agencies further demonstrated that funds for dental care were extremely limited. Unfortunately, dental treatment is funded under the Special Assistance Budget. Monies for this budget consist of equal federal and local contributions. Most municipalities were reluctant to further burden local taxpayers albeit recognizing the need for dental care for low income families.

Attempts to overcome this economic barrier have been time consuming to dental public health departments and even then, in many cases, full basic care was not undertaken. Too frequently it was not possible to arrange care, eventually triggering a referral to the local Child and Family Services. This process was wasteful of public health, social service, Child and Family Service resources, was unduly harsh to the families and often did not result in an adequate resolution of the child's needs.

The present government included at least three dental programs in its pre-election platform, one of them specifically directed toward basic dental care for children. In response to these statements, the OSPHD in April 1985, prepared an initial proposal for a plan limited to children identified at risk because, in their opinion, the province did not require a comprehensive, expensive denticare system directed to all children (Attachment #3). This proposal was supported by

the ODA and brought to the Minister of Health, the Honourable Murray Elston, for consideration. The government's intention was underlined by the announcement in the spring of 1986 that they were indeed committed to a program for children at risk.

Subsequently, Mr. Elston announced the formation of an Advisory Committee responsible to develop a plan for children with respresentation from public health, the two dental faculties and the ODA. The Committee agreed with the position of the OSPHD. The dental decay rates of Ontario children are the lowest in Canada. This along with better access to care, significant third party coverage and a higher general affluence means that this province does not need to implement an all-inclusive denticare program in order to resolve the immediate or urgent problems seen in a small percentage of children.

The Advisory Committee undertook its task with some specific assumptions. The system should be cost-effective, minimize the need for increased bureaucracy, be acceptable to the dental profession and ultimately ensure that no child in Ontario suffers from dental disease because of the family's financial limitations. Overall the Committee also accepted the philosophy initiated by the OSPHD that any plan should incorporate measures to permit effective cost containment, thereby ensuring that public resources would be carefully and well spent.

SUMMARY OF THE PROPOSED PROGRAM

The children determined by the proposed program to be at risk are identified by a mandatory health unit program whereby odd-aged children are screened annually and notices are sent to parents of children needing care. If the child is found to be in immediate or urgent need of care, the family has no third party coverage and declares that the cost would result in financial hardship, the child may attend a dentist of choice who will be paid by the health unit for services rendered. Health units will be funded 100 per cent by the Ministry of Health for this program.

Administrative details may be found beginning on page 10 under the "Program Administration" section.

DETERMINING THE EXTENT OF NEED

Dental Health Status of Ontario Children:

Since 1972 the Ministry of Health has conducted a biennial survey of the oral health of children (aged 5, 7, 9, 11 and 13) residing in Ontario. The Dental Health indices determined by the 1986 survey have been utilized as the basis for the present oral health status measurements.

The decayed, extracted, filled teeth (deft) and the Decayed, Missing, Filled Teeth (DMFT) index for children aged 5, 7, and 13 for each health unit participating in the survey compared to the provincial average is shown in Table 1. The ratio for each age (health unit average compared to provincial average) was determined. The three ratios were then averaged and indicated on the right hand column of Table 1.

The three ages selected to determine the ratios, represented children with only deciduous teeth (aged 5), children with only permanent teeth (aged 13) and one age with a mixed dentition (aged 7). Similarly, the Caries Treatment Requirement index (CTR) was used to determine the average ratio for the three age groups as indicated on the right hand column of Table 2. These three ages were used by the Committee because preliminary calculations indicated that the inclusion of ages 9 and 11 would not provide additional information.

By combining and averaging these two figures, Table 3 indicates, by health unit, the average ratio to the provincial average.

The Advisory Committee has used this average ratio for each health unit as an indicator of the relative weighting of the dental health status of the children within the area of the health unit.

Identifying Children's Treatment Needs:

For a number of years dental staff in many health units have identified dental needs of children screened under the mandatory preventive dentistry core program (Ontario Regulation 516/84 under the Health Protection & Promotion Act, 1983 - School Health Services and Programs). Each year pupils aged 5, 7, 9, 11 and 13 received a dental screening examination. Children identified as requiring immediate or urgent dental care require follow-up (Attachment #4).

Table 4 provides information on the number of children who received a dental screening examination and the number identified as requiring immediate or urgent dental treatment. Twenty-eight health units reported these numbers in the 1986 Survey of Ontario Health Unit Dental Departments. The table indicates that 3.15 percent of children screened by health unit staff require immediate or urgent dental treatment and who otherwise appear to meet requirements of eligibility.

Table 5 indicates the 1986 population estimates for children residing in Ontario. The total population of children aged 3 to 13 inclusive is 1,366,480. As 3.15 per cent were estimated to be at risk, then 43,380 children would have required assistance under the proposed dental treatment program in 1986.

DENTAL SERVICES PROVIDED TO ELIGIBLE CHILDREN

Preventive Services:

Under the mandatory requirements of the Health Protection & Promotion Act, health unit dental departments are required to offer particular preventive services to "high risk" children. These services may include individual oral hygiene instruction, topical fluoride application or other recognized preventive measures. Certainly, any child assessed in immediate or urgent need of dental care would be considered at "high risk" and thereby eligible for this service.

Logically, these preventive services should continue to be administered by the health unit. At this risk level, children require long term preventive interventions adapted to each student's unique needs. These could include other methods such as parent counselling, nutritional/diet assessment and counselling, home preventive programs (custom fluoride trays, home rinsing), fluoride supplements including home water testing, etc.

Dental staff visit schools frequently throughout the school year to ensure that the preventive regimens are maintained.

The local dentists should be made aware of the general outline of these services. Dentists providing care will need to be informed of the specific preventive regimen targeted for each child they treat under the program.

Treatment Services:

A general list of basic services was included in the OSPHD document (Attachment #3). Based on this list the Advisory Committee developed a Schedule outlining specific services by descriptions and by code (see Attachment #5). The schedule was developed in two parts. Part one outlines services which do not require predetermination (prior authorization), and Part two outlines services which require predetermination. Services listed in Part two are those that the Committee feels will be required from time to time and should be provided where they are essential to restore an individual child to good dental health. They require prior authorization to ensure the effectiveness and control costs of the program.

COSTS

In the first year of the plan odd-aged children (aged 5, 7, 9, 11 and 13) are included as well as the estimated 25% of preschool children (aged 3 and 4) who may be identified. The Advisory Committee recommends that the program incrementally add children up to and including age 16 by continuing maintenance in each year.

Therefore, in the funding requirements for year two, the costs of maintenance care for 14 year olds are included. Similarly, in year three, 14 and 15 year olds are included and in year four 14, 15 and 16 year olds are included.

Initial Funding Requirements:

Information from dental directors who have monitored costs of similar care to children requiring immediate or urgent dental care in 1986, indicates that an average cost of $340 per child was required to complete the initial treatment to bring these children to an adequate level of dental health (see Attachments #6a, b, c,d). The range of estimates was determined by the Northwestern experience of $410 (Attachment #6d) for a very high need group and that of Hastings & Prince Edward County ($298.92 - see Attachment #6c) for a more limited range of service benefits. The estimate of $340 was selected on the basis of Simcoe County's 1986 experience for a range of services similar to that proposed in the program in an area where children's dental health is at the provincial norm. (see Attachment #6b)

In the first year of the program approximately 3.15 percent (21,586) of Ontario children will require immediate or urgent care (see Table 4). Costs of the first year will approximate $7,339,240 (see Table 6, year 1).

Projected Funding Requirements:

The second year of the program will include a new group of odd-aged children requiring initial care and the children treated in the first year requiring less expensive maintenance care. Information from the field indicates that an average of $115 was required to maintain these children at an adequate level of dental health (see Attachment #6d, and Attachments #7a, b & c).

Funding required in the second year of the program would be $9,771, 310 (see Table 6, year 2).

The third year of the program will include all eligible children identified in the first and second years. Maintenance care only will be required for both groups. Information from the field indicates that an average of $87 was required to complete ongoing maintenance care (see Attachments #7a, b & c). One new age group, the 5 year old children, will require initial care at $340 per child.

Funding required in the third year of the program would be $5,696,212 (see Table 6, year 3). Funding for the fourth year of the program would be $5,550,473. In subsequent years the costs of the program should be stable at approximately 5.6 million in 1986 dollars.

The Committee has estimated the number of children eligible and costs on the assumption that the following factors will continue:

- economic prosperity in Ontario;
- low prevalence of dental disease in Ontario children;
- high prevalence of dental insurance among Ontario workers and their dependents;
- comprehensive dental benefits through insured schemes;
- no in-migration of large numbers of children at risk;
- dental fees remain constant with inflation.

SUMMARY OF PROJECTED COSTS

Year 1 ..... $7,339,240

Year 2 ..... $9,771,310

Year 3 ..... $5,696,212

Year 4 ..... $5,550,473

GRANTS TO HEALTH UNITS

The terms of reference indicate that payment to dentists for services provided to eligible children will be made by the health unit. The Ministry of Health will provide funding through transfer payments to health units.

Tables 7, 8 and 9 indicate the funding required by each health unit for the first, second and third years. The adjusted provincial cost per child of $5.37 was determined by dividing the estimated first year cost (Table 6) by the number of children in the province from age 3 to 13 inclusive. In order to equitably allocate funds to health units reflecting the dental health status of children residing in their area, the relative rates determined in Table 3 were applied to the average cost per child of $5.37. Similarly this method was applied for years 2 and 3 of the program as shown in Tables 8 and 9.

For example, applying this formula to the Porcupine Health Unit which has more dental disease than the provincial average results in a grant in the first year of $13.75 per child. Conversely, in East York Health Unit where disease rates are among the lowest in the province, the per child grant is only $3.38.

For health units where statistical information was not available, calculations were based on dates from a similar contiguous health unit.

FINANCIAL ASSESSMENT OF ELIGIBILITY

There are two choices -- means testing or no means testing. By means testing we refer to a system whereby:

(1) specific details of family income and outflow are required;
(2) some authority has established an arbitrary level of available funds which should permit a family to afford dental care.

Data presented to the Committee showed that the cost of accurate means testing was over $100 for each assessment. Difficulties arising from arbitrary guidelines were also discussed. The Committee decided that a means test is not only costly, invasive of privacy, and demeaning, but could defeat the purpose of the program if parents chose not to submit.

Children covered by the program must be in immediate or urgent need of treatment. Health unit dental directors agree that, by far, the majority of these children belong to low/marginal income families.

For this reason, it was decided to define eligible children as those whose parents do not have third party coverage and who would sign a statement that the costs of dental care for the child would impose a financial hardship. These criteria would be declared in the original notification of need sent to parents (see Attachment #8). As well, a parent or guardian would attest to the financial hardship by signature on the claim form issued by the health unit (see Attachment #9).

ADMINISTRATION OF THE PROPOSED PROGRAM

Where a child is determined to be eligible, the family is forwarded a program claim form (see Attachment #9). Health unit staff will have completed the sections of the form which identify the child and the health unit. On the form is a section requiring parent/guardian signature which reasserts their claim of eligibility.

The form presented to the child's dentist by the family indicates to the dentist that dental services listed in the schedule (Attachment #5) will be paid by the program. On completion of care, the form is sent to the health unit for payment. Interim statements may also be submitted before treatment is complete. In this case another claim form will be prepared by health unit staff and forwarded to the dentist for subsequent invoicing. Subsequent forms will not require signature by the parent or guardian.

Where health units operate dental treatment programs, particular arrangements will have to be made to draw funds from the proposed program to pay for the services provided to eligible children.

Use of the Management Information System (MoH):

Health unit staff will carefully scrutinize the forms, pay the dentist and regularly forward a copy of the claim to the Management Information Branch at the Ministry of Health. A Management Information System is currently being developed by the Ministry for use by the Ministry's Underserviced Area Program. This system was described to the Advisory Committee in order to consider its use by the children's dental plan to record services provided. This would be a comprehensive accountability information system and provide indicators of productivity, current expenditures, etc. The system will also cross check the claim in order to identify treatment discrepancies which could affect reimbursement. The dental director will take the responsibility to clarify any discrepancies with the attending dentist and submit the revised information.

Payment Mechanism:

Health units will pay dentists their usual and customary fee up to 90 percent of the current ODA Suggested Fee Guide for General Practitioners or up to 120 percent of the general practitioners fee for specialists.

The dental director will forward claims to the business office at the health unit. Cheques will be issued and the dental department informed to verify payments.

Health units may also pay dentists a sessional or per diem rate under special arrangements.

Ongoing Case Management:

In each subsequent year, in view of their high risk status, treated children will be re-examined. Eligibility under the program is continued if treatment needs are found and the family's financial and dental coverage status has not changed. Notifications will be sent to eligible families whose children have progressed to the secondary school level (eventually up to age 16). On request, arrangements can be made with the dental department for a screening of these children in order to ascertain their dental health and eligibility status.

Health Unit Administrative Costs:

Health units may require additional staff to administer the program. Above the present requirements of the screening program, it will be necessary to forward program claim forms to families, process claims returned from dentists, forward appropriate information to the Management Information Branch at the Ministry, etc.

The Committee recommends that the health units may use up to 3 per cent of the funds provided to defray the units administrative costs.

Health Unit Grant Appeal:

To arrive at the percentage of children in immediate or urgent need of care, the Committee used data from 28 health units recognizing that these data were not gathered using uniform criteria. Although the overall percentage so calculated approximates the provincial average for eligible children, it may vary somewhat in an individual health unit. It is expected that most, but not all children identified as requiring immediate or urgent treatment will meet the eligibility criteria. Therefore, the number of children receiving treatment under the program should not exceed the estimated 3.15 per cent.

The Committee recommends that an appeal be allowed by a health unit if the number of identified children exceeds the estimated average.

Review of the Program:

Because of the innovative nature of a program directed toward

Ontario children at risk, it may be anticipated that some discrepancies will arise within the first year or so of experience. For that reason, this Committee or a like body should be maintained in order to assess problems, such as grant appeals, etc., and recommend program adjustments.

In addition, relevant data will be gathered by health unit dental departments and the management information system at the Ministry. This material should be examined and incorporated into a refined version of this program.

COMMUNICATIONS PLAN

Health units, Social Services, Child and Family Service agencies, and the dental profession eagerly await implementation of the program which will resolve current serious problems. Consequently, it needs to be initiated at the earliest opportunity.

The profession will best be informed by a descriptive mail-out released by the Ministry of Health in cooperation with the O.D.A. The information packet would include a description of the program, the Schedule of Benefits, outline the responsibility of the private dental office and the health unit, include samples of the claim form and instruction on use, etc.

The proposed program would be implemented best through regional workshops sponsored by the Ministry to which local dentists and public health staff would be invited.

TABLE 1

CARIES PREVALENCE FOR THE 43 HEALTH UNITS RELATIVE TO ONTARIO AVERAGE

		AGE 5 (deft)	RATIO TO PROVINCE	AGE 7 (deft-DMFT)	RATIO TO PROVINCE	AGE 13 (DMFT)	RATIO TO PROVINCE	MEAN RATIO FOR 3 AGE GROUPS	
	PROVINCE	1.20		2.37		2.51			
HEALTH UNIT									
1.	Algoma	1.78	1.48	3.91	1.65	3.89	1.55	1.56	Algoma
2.	Brant	1.07	0.89	2.31	0.97	2.16	0.86	0.91	Brant
3.	Bruce	1.15	0.96	2.29	0.96	2.80	1.12	1.01	Bruce
4.	Ottawa	0.87	0.73	1.73	0.77	2.01	0.80	0.77	Ottawa
5.	Porcupine	2.60	2.17	3.92	1.65	4.47	1.78	1.86	Porcupine
6.	Elgin St. Thomas	1.25	1.04	2.15	0.90	2.21	0.88	0.94	Elgin
7.	Windsor	1.31	1.09	2.38	1.00	2.31	0.92	1.00	Windsor
8.	Grey-Owen Sound	0.92	0.77	2.05	0.86	2.17	0.86	0.83	Grey
9.	Haldimand*								
10.	Halton*								
11.	Hastings	1.44	1.20	2.06	0.86	1.92	0.79	0.95	Hastings
12.	Huron	1.01	0.84	2.24	0.95	2.45	0.96	0.91	Huron
13.	Northwestern	1.80	1.50	3.44	1.48	3.27	1.30	1.43	Northwestern
14.	Kent-Chatham	1.67	1.39	2.99	1.26	2.90	1.15	1.27	Kent-Chatham
15.	Kingston	1.14	0.95	1.94	0.82	1.76	0.70	0.82	Kingston
16.	Lambton	1.10	0.92	2.70	1.14	2.08	1.23	1.09	Lambton
17.	Leeds-Grenville	1.06	0.88	2.13	0.90	2.13	0.85	0.88	Leeds
18.	Middlesex-London	0.89	0.74	1.48	0.62	1.96	0.78	0.71	Middlesex-London
19.	Muskoka Parry Sound	1.49	1.24	2.68	1.13	2.54	1.01	1.13	Muskoka
20.	Niagara	1.17	0.97	2.44	1.03	2.92	1.16	1.05	Niagara
21.	North Bay*								

TABLE 1
(continued)

		AGE 5 (deft)	RATIO TO PROVINCE	AGE 7 (deft-DMFT)	RATIO TO PROVINCE	AGE 13 (DMFT)	RATIO TO PROVINCE	MEAN RATIO FOR 3 AGE GROUPS	
	PROVINCE	1.20		2.37		2.51			
HEALTH UNIT									
22.	Haliburton	1.17	0.97	2.38	1.00	2.61	1.94	1.00	Haliburton
23.	Durham*								
24.	Oxford	0.97	0.81	2.03	0.97	2.15	0.86	0.88	Oxford
25.	Peel*								
26.	Perth	0.63	0.53	1.65	0.70	1.83	0.73	0.65	Perth
27.	Peterborough	0.85	0.71	1.70	0.72	2.10	0.84	0.76	Peterborough
28.	Renfrew	1.55	1.29	2.85	1.20	2.02	1.20	1.23	Renfrew
29.	Eastern Ontario	1.04	1.04	2.05	1.00	2.80	1.11	1.05	Eastern
30.	Simcoe	1.22	1.01	2.61	1.10	2.93	1.17	1.09	Simcoe
31.	Sudbury	2.08	1.73	3.91	1.65	3.73	1.48	1.62	Sudbury
32.	Thunder Bay	1.53	1.27	2.87	1.21	2.69	1.03	1.17	Thunder Bay
33.	Timiskaming*								
34.	Waterloo	1.13	0.94	2.27	0.96	2.27	0.90	0.93	Waterloo
35.	Wellington-Dufferin	1.25	1.03	2.56	1.08	2.82	1.12	1.07	Wellington
36.	Hamilton	1.37	1.14	2.70	1.14	2.41	0.96	1.08	Hamilton
37.	Etobicoke	1.24	1.02	2.34	0.98	2.49	0.99	1.00	Etobicoke
38.	North York	1.29	1.07	2.69	1.13	2.65	1.05	1.08	North York
39.	Scarborough	1.06	0.88	2.06	0.87	2.50	1.00	0.92	Scarborough
40.	Toronto	1.11	0.92	2.25	0.95	2.30	0.92	0.93	Toronto
41.	York City	1.28	1.06	2.25	0.95	2.00	0.80	0.94	York City
42.	York Regional	1.11	0.92	1.99	0.84	2.96	1.18	0.98	York Region
43.	East York	0.88	0.73	1.76	0.74	2.20	0.87	0.78	East York

*NO INFORMATION AVAILABLE

TABLE 2

CARIES TREATMENT REQUIREMENTS (C.T.R.) FOR THE 43 HEALTH UNITS RELATIVE TO ONTARIO AVERAGE

		AGE 5 (CTR)	RATIO TO PROVINCE	AGE 7 (CTR)	RATIO TO PROVINCE	AGE 13 (CTR)	RATIO TO PROVINCE	MEAN RATIO FOR 3 AGE GROUPS	
	PROVINCE	0.43		0.48		0.28			
HEALTH UNIT									
1.	Algoma	0.43	1.0	0.60	1.25	0.30	1.07	1.10	Algoma
2.	Brant	0.31	0.72	0.31	0.64	0.13	0.46	0.61	Brant
3.	Bruce	0.39	0.	42	0.87	0.23	0.82	0.87	Bruce
4.	Ottawa	0.30	0.70	0.32	0.66	0.12	0.43	0.60	Ottawa
5.	Porcupine	1.31	3.04	1.31	2.73	1.12	4.00	3.25	Porcupine
6.	Elgin St. Thomas	0.58	1.35	0.61	1.27	0.48	1.71	1.44	Elgin
7.	Windsor	0.59	1.37	0.57	1.19	0.22	0.78	1.11	Windsor
8.	Grey-Owen Sound	0.34	0.79	0.40	0.83	0.18	0.64	0.75	Grey
9.	Haldimand*								
10.	Halton*								
11.	Hastings	0.58	1.35	0.59	1.23	0.27	0.96	1.18	Hastings
12.	Huron	0.22	0.51	0.36	0.75	0.16	0.57	0.61	Huron
13.	Northwestern	0.79	1.83	0.74	1.54	0.27	0.96	1.44	Northwestern
14.	Kent-Chatham	0.71	1.65	0.98	2.04	0.76	2.71	1.95	Kent-Chatham
15.	Kingston	0.47	1.09	0.50	1.04	0.27	0.96	1.03	Kingston
16.	Lambton	0.13	0.30	0.18	0.38	0.03	0.11	0.26	Lambton
17.	Leeds-Grenville	0.37	0.86	0.54	1.12	0.23	0.82	0.93	Leeds
18.	Middlesex-London	0.14	0.33	0.17	0.35	0.07	0.25	0.31	Middlesex-London
19.	Muskoka Parry Sound	0.67	1.56	0.49	1.02	0.29	1.04	1.21	Muskoka
20.	Niagara	0.36	0.84	0.44	0.92	0.28	1.00	0.92	Niagara
21.	North Bay*								

TABLE 2
(continued)

		AGE 5 (CTR)	RATIO TO PROVINCE	AGE 7 (CTR)	RATIO TO PROVINCE	AGE 13 (CTR)	RATIO TO PROVINCE	MEAN RATIO FOR 3 AGE GROUPS	
	PROVINCE	0.43		0.48		0.28			
HEALTH UNIT									
22.	Haliburton	0.41	0.95	0.55	1.15	0.34	1.21	1.10	Haliburton
23.	Durham*								
24.	Oxford	0.22	0.51	0.31	0.65	0.14	0.50	0.55	Oxford
25.	Peel*								
26.	Perth	0.15	0.35	0.18	0.38	0.05	0.18	0.30	Perth
27.	Peterborough	0.35	0.81	0.32	0.66	0.11	0.39	0.62	Peterborough
28.	Renfrew	0.71	1.65	0.90	1.87	0.76	2.71	2.08	Renfrew
29.	Eastern Ontario	1.04	1.04	2.05	1.00	2.80	1.11	1.88	Eastern
30.	Simcoe	0.39	0.91	0.45	0.94	0.29	1.03	0.96	Simcoe
31.	Sudbury	0.87	2.02	1.09	2.27	1.00	3.57	2.62	Sudbury
32.	Thunder Bay	0.41	0.95	0.55	1.15	0.18	0.64	0.91	Thunder Bay
33.	Timiskaming*								
34.	Waterloo	0.24	0.56	0.28	0.58	0.08	0.29	0.48	Waterloo
35.	Wellington-Dufferin	0.38	0.88	0.48	1.00	0.33	1.18	1.02	Wellington
36.	Hamilton	0.51	1.19	0.70	1.45	0.40	1.43	1.35	Hamilton
37.	Etobicoke	0.60	1.39	0.60	1.25	0.43	1.53	1.39	Etobicoke
38.	North York	0.28	0.65	0.32	0.66	0.16	0.57	0.63	North York
39.	Scarborough	0.40	0.93	0.36	0.75	0.30	1.07	0.92	Scarborough
40.	Toronto	0.37	0.86	0.31	0.65	0.27	0.96	0.82	Toronto
41.	York City	0.54	1.25	0.50	1.04	0.34	1.21	1.17	York City
42.	York Regional	0.49	1.14	0.43	0.90	0.39	1.39	1.14	York Region
43.	East York	0.28	0.65	0.16	0.33	0.13	0.46	0.48	East York

*NO INFORMATION AVAILABLE

TABLE 3

DENTAL HEALTH STATUS FOR THE 43 HEALTH UNITS RELATIVE TO ONTARIO AVERAGE

	HEALTH UNIT	deft DMFT MEAN RATIO	C.T.R. MEAN RATIO	AVERAGE RATIO
1.	Algoma	1.56	1.10	1.33
2.	Brant	0.91	0.61	0.76
3.	Bruce	1.01	0.87	0.94
4.	Ottawa	0.77	0.60	0.69
5.	Porcupine	1.86	3.25	2.56
6.	Elgin St. Thomas	0.94	1.44	1.19
7.	Windsor	1.00	1.11	1.06
8.	Grey-Owen Sound	0.83	0.75	0.79
9.	Haldimand*			
10.	Halton*			
11.	Hastings	0.95	1.18	1.07
12.	Huron	0.91	0.61	0.76
13.	Northwestern	1.43	1.44	1.44
14.	Kent-Chatham	1.27	1.95	1.61
15.	Kingston	0.82	1.03	0.93
16.	Lambton	1.09	0.26	0.68
17.	Leeds-Grenville	0.88	0.93	0.91
18.	Middlesex-London	0.71	0.31	0.51
19.	Muskoka Parry Sound	1.13	1.21	1.17
20.	Niagara	1.05	0.92	0.99
21.	North Bay*			
22.	Haliburton	1.00	1.10	1.05
23.	Durham*			
24.	Oxford	0.88	0.55	0.72
25.	Peel*			
26.	Perth	0.65	0.30	0.48
27.	Peterborough	0.76	0.62	0.69
28.	Renfrew	1.23	2.08	1.66
29.	Eastern Ontario	1.05	1.88	1.47
30.	Simcoe	1.09	0.96	1.03
31.	Sudbury	1.62	2.62	2.12
32.	Thunder Bay	1.17	0.91	1.04
33.	Timiskaming*			
34.	Waterloo	0.93	0.48	0.72
35.	Wellington-Dufferin	1.07	1.02	1.05
36.	Hamilton	1.08	1.35	1.22
37.	Etobicoke	1.00	1.39	1.20
38.	North York	1.08	0.63	0.86
39.	Scarborough	0.92	0.92	0.92
40.	Toronto	0.93	0.82	0.88
41.	York City	0.94	1.17	1.06
42.	York Regional	0.98	1.14	1.06
43.	East York	0.78	0.48	0.63

*NO INFORMATION AVAILABLE

TABLE 4

NUMBER OF CHILDREN IN IMMEDIATE OR URGENT NEED OF DENTAL CARE
FROM 1986 SURVEY

HEALTH UNIT	NUMBER OF CHILDREN SCREENED	NUMBER OF CHILDREN IN IMMEDIATE OR URGENT NEED OF DENTAL CARE
Algoma	2701	144
Bruce	4061	55
East York	4021	81
Eastern Ontario	8333	121
Elgin St. Thomas	4236	347
Etobicoke	13275	277
Grey-Owen Sound	5471	431
Haliburton	8011	218
Hastings	9091	236
Huron	4110	44
Kingston	8018	168
Lambton	8248	228
Leeds-Grenville	8257	130
Middlesex-London	31197	811
Muskoka Parry Sound	4133	264
Niagara	12070	359
Northwestern	5050	1078
North York	6525	131
Ottawa	16635	607
Oxford	6052	122
Perth	4857	28
Peterborough	5300	136
Porcupine	3999	308
Renfrew	1669	163
Scarborough	28447	535
Simcoe	15995	625
Waterloo	24263	399
Wellington-Dufferin	2246	32
	256,251	8,078
		= 3.15%

TABLE 5

POPULATION ESTIMATES FOR 1986

AGE		
3	-	126,310
4	-	124,400
5	-	123,000
6	-	123,510
7	-	121,040
8	-	121,040
9	-	122,510
10	-	124,590
11	-	127,640
12	-	124,030
13	-	128,430
	TOTAL	1,366,480

TABLE 6

INITIAL AND PROJECTED FUNDING REQUIREMENTS[1]

YEAR 1

AGE 5	-	123,000
7	-	121,020
9	-	122,510
11	-	127,640
13	-	128,430
(25%) 3 & 4	-	62,677
		685,277[2]

(1) 3.15% at risk
3.15% of 685,277 = 21,586

21,586 children at $340.00 (initial care)

TOTAL COST FOR YEAR 1 = $7,339,240.

YEAR 2

AGE 5	-	124,400
7	-	123,510
9	-	121,040
11	-	124,590
13	-	124,030
(25%) 3 & 4	-	63,000
		680,570[2]

(1) 3.15% at risk
3.15% of 680,570 = 21,438

21,438 children at $340.00 (initial care)
= $7, 288,920.

(2) Maintenance Care for Year 1 Children
21,586 children at $115.00 (maintenance)
= $2,482,390.

TOTAL COST FOR YEAR 2 = $9,771,310

YEAR 3

(1) Year 1 children = 21,586
Now on second year of maintenance at $87.00

21,586 children at $87.00 = $1,877,982.

(2) Year 2 children = 21,438
First year of maintenance at $115.00

21,438 children at $115.00 = $2,465,370.

(3) Number of 5 year olds = 126,310
3.15% at risk = 3,979 children

3,979 children at $340.00 (initial care) = $1,352,860.

TOTAL COST FOR YEAR 3 = $5,696,212

YEAR 4

(1) 3,979 children on first year of maintenance care
3,979 children at $115.00 = $457,585.

(2) 43,024 children on ongoing maintenance at $87.00
43,024 children at $87.00 = $3,743,088.

(3) Number of 5 year olds = approx. 126,000
3.15% at risk = 3,970.
3,970 children at $340.00 (initial care) = $1,349,800.

TOTAL COST FOR YEAR 4 = $5,550,473

(1) Based on 1986 dollars
(2) Provincial population figures vary slightly from health unit estimates on Tables 7,8 and 9.

TABLE 7

GRANTS TO HEALTH UNITS - YEAR 1 (1986 Dollars)

HEALTH UNIT CODE	HEALTH UNIT NAME	DMFT, CTR RATIO (To Provincial Average)	ADJUSTED PER CAPITA (Based on $5.37/child)	NUMBER OF CHILDREN (age 5-13y 25% of 3+4yrs)	FUNDING YEAR 1
1.	Algoma	1.33	7.14	22,078	$157,635.
2.	Brant	0.76	4.08	16,370	66,790.
3.	Bruce	0.94	5.05	8,560	43,230.
4.	Ottawa	0.69	3.70	88,060	325,820.
5.	Porcupine	2.56	13.75	19,900	273,625.
6.	Elgin St. Thomas	1.19	6.39	12,800	81,790.
7.	Windsor	1.06	5.69	45,800	260,600.
8.	Grey-Owen Sound	0.79	4.24	11,950	50,670.
9.	Haldimand	(0.80)*	4.30	12,840	55,210.
10.	Halton	(0.80)*	4.30	43,385	186,555.
11.	Hastings	1.07	5.75	21,000	120,750.
12.	Huron	0.76	4.08	8,345	34,050.
13.	Northwestern	1.44	7.73	11,880	91,830.
14.	Kent-Chatham	1.61	8.65	16,245	140,520.
15.	Kingston	0.93	4.99	23,865	119,085.
16.	Lambton	0.68	3.65	22,015	80,355.
17.	Leeds-Grenville	0.91	4.89	21,290	104,110.
18.	Middlesex-London	0.51	2.74	44,510	121,960.
19.	Muskoka Parry Sound	1.17	6.28	9,870	61,985.
20.	Niagara	0.99	5.32	55,260	293,980.
21.	North Bay	(1.17)*	6.28	15,395	96,680.
22.	Haliburton	1.05	5.64	20,320	114,605.
23.	Durham	(1.00)*	5.37	44,220	237,460.
24.	Oxford	0.72	3.87	12,380	47,910.
25.	Peel	(0.80)*	4.30	94,600	406,780.
26.	Perth	0.48	2.58	11,560	29,825.
27.	Peterborough	0.69	3.70	16,725	61,880.
28.	Renfrew	1.66	8.91	14,160	126,165.
29.	Eastern Ontario	1.47	7.89	26,105	205,970.
30.	Simcoe	1.03	5.53	36,510	201,900.
31.	Sudbury	2.12	11.38	36,105	410,875.
32.	Thunder Bay	1.04	5.58	25,680	143,295.
33.	Timiskaming	(2.00)*	10.74	6,845	73,515.
34.	Waterloo	0.72	3.87	51,465	199,170.
35.	Wellington-Dufferin	1.05	5.64	26,240	147,995.
36.	Hamilton	1.22	6.55	59,070	386,910.
37.	Etobicoke	1.20	6.44	39,330	253,285.
38.	North York	0.86	4.62	86,460	399,445.
39.	Scarborough	0.92	4.94	76,110	375,985.
40.	Toronto	0.88	4.73	70,525	333,585.
41.	York City	1.06	5.69	19,825	112,805.
42.	York Regional	1.06	5.69	49,860	283,705.
43.	East York	.63	3.38	9,735	32,905.
				1,365,848	$7,353,200.

*NO INFORMATION ON DMFT OR CTR

TABLE 8

GRANTS TO HEALTH UNITS - YEAR 2 (1986 Dollars)

CODE	HEALTH UNIT NAME	DMFT CTR RATIO (To Provincial Average)	ADJUSTED PER CAPITA (Based on $7.15/child)	NUMBER OF CHILDREN (age 5-13y 25% of 3+4yrs)	FUNDING YEAR 2
1.	Algoma	1.33	9.51	22,078	$209,962.
2.	Brant	0.76	5.43	16,370	88,889.
3.	Bruce	0.94	6.72	8,560	57,523.
4.	Ottawa	0.69	4.93	88,060	434,136.
5.	Porcupine	2.56	18.30	19,900	364,170.
6.	Elgin St. Thomas	1.19	8.51	12,800	108,928.
7.	Windsor-Essex	1.06	7.58	45,800	347,164.
8.	Grey-Owen Sound	0.79	5.65	11,950	67,517.
9.	Haldimand	(0.80)*	5.72	12,840	73,445.
10.	Halton	(0.80)*	5.72	43,385	248,162.
11.	Hastings	1.07	7.65	21,000	160,650.
12.	Huron	0.76	5.43	8,345	45,313.
13.	Northwestern	1.44	10.30	11,880	122,364.
14.	Kent-Chatham	1.61	11.51	16,245	186,980.
15.	Kingston	0.93	6.65	23,865	158,702.
16.	Lambton	0.68	4.86	22,015	106,993.
17.	Leeds-Grenville	0.91	6.51	21,290	138,598.
18.	Middlesex-London	0.51	3.65	44,510	162,461.
19.	Muskoka Parry Sound	1.17	8.37	9,870	82,612.
20.	Niagara	0.99	7.08	55,260	391,241.
21.	North Bay	(1.17)*	8.37	15,395	128,856.
22.	Haliburton	1.05	7.51	20,320	152,603.
23.	Durham	(1.00)*	7.15	44,220	316,173.
24.	Oxford	0.72	5.15	12,380	63,757.
25.	Peel	(0.80)*	5.72	94,600	541,112.
26.	Perth	0.48	3.43	11,560	39,651.
27.	Peterborough	0.69	4.93	16,725	82,454.
28.	Renfrew	1.66	11.87	14,160	168,079.
29.	Eastern Ontario	1.47	10.51	26,105	274,364.
30.	Simcoe	1.03	7.36	36,510	268,714.
31.	Sudbury	2.12	15.16	36,105	547,352.
32.	Thunder Bay	1.04	7.44	25,680	191,059.
33.	Timiskaming	(2.00)*	14.30	6,845	97,883.
34.	Waterloo	0.72	5.15	51,465	265,045.
35.	Wellington-Dufferin	1.05	7.51	26,240	197,062.
36.	Hamilton	1.22	8.72	59,070	515,090.
37.	Etobicoke	1.20	8.58	39,330	337,451.
38.	North York	0.86	6.15	86,460	531,729.
39.	Scarborough	0.92	6.58	76,110	500,804.
40.	Toronto	0.88	6.30	70,525	444,307.
41.	York City	1.06	7.58	19,825	150,274.
42.	York Regional	1.06	7.58	49,860	377,939.
43.	East York	0.63	4.50	9,735	43,808.
				1,365,848	$9,791,376.

*NO INFORMATION ON DMFT OR CTR

TABLE 9

GRANTS TO HEALTH UNITS - YEAR 3 (1986 Dollars)

CODE	HEALTH UNIT NAME	DMFT, CTR RATIO (To Provincial Average)	ADJUSTED PER CAPITA (Based on $4.17/child)	NUMBER OF CHILDREN (age 5-13y 25% of 3+4yrs)	FUNDING YEAR 3
1.	Algoma	1.33	5.55	22,078	$122,533.
2.	Brant	0.76	3.17	16,370	51,893.
3.	Bruce	0.94	3.92	8,560	33,555.
4.	Ottawa	0.69	2.88	88,060	253,613.
5.	Porcupine	2.56	10.66	19,900	212,134.
6.	Elgin St. Thomas	1.19	4.96	12,800	63,488.
7.	Windsor	1.06	4.42	45,800	202,436.
8.	Grey-Owen Sound	0.79	3.29	11,950	39,316.
9.	Haldimand	(0.80)*	3.34	12,840	42,886.
10.	Halton	(0.80)*	3.34	43,385	144,906.
11.	Hastings	1.07	4.46	21,000	93,660.
12.	Huron	0.76	3.17	8,345	26,454.
13.	Northwestern	1.44	6.00	11,880	71,280.
14.	Kent-Chatham	1.61	6.71	16,245	109,004.
15.	Kingston	0.93	3.88	23,865	92,596.
16.	Lambton	0.68	2.84	22,015	62,523.
17.	Leeds-Grenville	0.91	3.79	21,290	80,689.
18.	Middlesex-London	0.51	2.13	44,510	94,806.
19.	Muskoka Parry Sound	1.17	4.88	9,870	48,166.
20.	Niagara	0.99	4.13	55,260	228,224.
21.	North Bay	(1.17)*	4.88	15,395	75,128.
22.	Haliburton	1.05	4.38	20,320	89,002.
23.	Durham	(1.00)*	4.17	44,220	184,397.
24.	Oxford	0.72	3.00	12,380	37,140.
25.	Peel	(0.80)*	3.34	94,600	315,964.
26.	Perth	0.48	2.00	11,560	23,120.
27.	Peterborough	0.69	2.88	16,725	48,168.
28.	Renfrew	1.66	6.92	14,160	97,987.
29.	Eastern Ontario	1.47	6.13	26,105	160,024.
30.	Simcoe	1.03	4.30	36,510	156,993.
31.	Sudbury	2.12	8.84	36,105	319,168.
32.	Thunder Bay	1.04	4.34	25,680	111,451.
33.	Timiskaming	(2.00)*	8.34	6,845	57,087.
34.	Waterloo	0.72	3.00	51,465	154,395.
35.	Wellington-Dufferin	1.05	4.38	26,240	114,931.
36.	Hamilton	1.22	5.09	59,070	300,666.
37.	Etobicoke	1.20	5.00	39,330	196,650.
38.	North York	0.86	3.59	86,460	310,391.
39.	Scarborough	0.92	3.84	76,110	292,262.
40.	Toronto	0.88	3.67	70,525	258,827.
41.	York City	1.06	4.42	19,825	87,626.
42.	York Regional	1.06	4.42	49,860	220,381.
43.	East York	.63	2.63	9,735	25,603.
				1,365,848	$5,711,522.

*NO INFORMATION ON DMFT OR CTR

ATTACHMENT #1

RECOMMENDED PROCEDURES

FOR IDENTIFYING AND REPORTING SUSPECTED CHILD ABUSE RESULTING FROM DENTAL NEGLECT FOR PUBLIC HEALTH DENTAL DEPARTMENTS

Revised: July 1986
Public Health Branch
Ontario Ministry of Health

PROJECT TEAM MEMBERS

TEAM MEMBER	REPRESENTING
Dr. K. Fitzgerald	Society of Medical Officers of Health of Ontario
Mr. J. Gillies	Ontario Dental Association
Dr. D. McFarlane	Royal College of Dental Surgeons of Ontario
Mr. S. Handler	Operational Support Branch Ministry of Community and Social Services
Dr. T. Hicks Dr. A. Glenny Dr. N. Farrell	The Ontario Society of Public Health Dentists
Miss J. Thomson Dr. K. Ryan (Project Manager)	Public Health Resource Service Ministry of Health

Introduction

There are certain dental conditions, which if left untreated following adequate and appropriate notification could result in a child being found to be in need of protection within the meaning of the Act respecting the Protection and Well-being of Children and their Families (Child and Family Services Act).

Where a person who has charge of a child does not provide, refuses or is unable to consent to treatment to cure, prevent or alleviate physical harm or suffering or where a child has suffered physical harm by a person's failure to care and provide for and protect the child adequately, this would indicate the child is in need of protection (Section 37 (2)).

Section 68 of the Act states "to suffer abuse" refers to a child in need of protection within the meaning of Clause 37 (2) (a), (e). The section further states the duty to report a child in need of protection and also indicates that a person in the course of his or her professional or official duties shall report a child who is suffering or has suffered abuse.

As a result of certain dental programs, dental staff employed by health units may encounter children presenting with dental conditions which can, if not rectified, lead to a situation of a child being in need of protection and being deemed "to suffer abuse" which is reportable under Section 68 of the Child and Family Services Act.

At present a variety of systems have been developed by individual Health Units to handle children in immediate (acute) or urgent need of dental care. These range from the provision of comprehensive dental care in a Health Unit Dental Treatment Program, through various agreements with local agencies (official or private service clubs), to situations where no stated protocol was apparent.

The proposed recommended procedures address the description of oral conditions requiring immediate/acute and urgent care and a protocol outlining a suggested procedure to follow after a child has been identified as requiring care.

The definition or description of dental neglect was developed with and endorsed by the Ontario Dental Association.

The protocol for follow-up of identified children is a recommended procedure only. Whatever system is developed by individual Health Units, it should reflect a positive attitude in assisting the family to resolve an important problem and not an autocratic method of forcing parental compliance. Referral to the Children's Aid Society would be undertaken only if all other options have been exhausted within the time allotment.

ORAL CONDITIONS RENDERING A CHILD IN NEED OF PROTECTION

A child would be in need of protection if there was failure on the part of the parent or guardian to remedy these oral conditions after having been informed of these conditions.

THESE CONDITIONS INCLUDE:

1. Immediate (acute) need for care due to:

   a) Pain - conditions which are presently causing pain or have caused pain frequently in the time period immediately preceeding assessment.

   b) Infection -

      1) visually apparent abscesses and reports of abscesses or swellings.

      2) gingival conditions (acute) requiring immediate attention such as necrotizing ulcerative gingivitis and any suppurative gingival conditions that would cause abnormal or extreme gingival conditions.

   c) Haemorrhage - most haemorrhage from gingival conditions would be reported under infection. Haemorrhage may also occur from trauma or accidents or subsequent to dental surgery.

   d) Trauma - to premaxilla, maxillae and/or mandible area which does or may affect the teeth and supporting structures including crucial primary teeth.

e) Pathology - any specific pathological condition of the hard or soft tissues where further investigation is recommended and developmental anomalies or pathology of potentially serious nature.

2. Urgent need for care due to:

Conditions which would lead to pain, infection or haemorrhage such as:

a) CARIES

1. In Permanent teeth

2. Primary teeth - lesions in crucial primary teeth

b) PERIODONTAL DISEASE

- periodontal disease which is not reversible by adequate oral hygiene.

FOLLOW-UP PROTOCOL FOR PUBLIC HEALTH IDENTIFIED CHILDREN

Urgent Cases

STEPS	PERSONNEL
1. Primary identification	dental health educator (elementary) public health nurse (secondary) dental hygienist (elementary) classroom teacher
2. Technical assessment	dental hygienist (dental director/dentist)
3. Initial parent notification	referral card to parent
4. Parent follow-up	by telephone or mail - (dental staff)
5. Second parent follow-up	public health nurse
6. Reassessment	dental director/dentist
7. Final disposition (2 months)	Children's Aid Society

COMMENTS

Step 1: Most cases will be initiated by hygienists as Screening, Referral, Follow-up and Survey Programme is mandated.

Step 2: Hygienists are professionally competent to make the technical assessment. If hygienist not employed by a Health Unit, the dental director would be obligated. In units employing dentists for treatment programme, these individuals could be utilized. In health units with part-time directors, arrangements could be made with a local private practice dentist.

Step 3: A referral card or form letter could be sent out by the dental department informing the parent of need and requesting return by a dentist upon completion of treatment of the urgent conditions. (see Appendix A and B).

Step 4: Parent contacted by telephone or mail by dental personnel.

Step 5: Inaction by parent would initiate an appropriate follow-up by public health nurse. (see Appendix D).

Step 6: If no compliance or parental refusal, dental director should reassess the conditions and send parent final written notification by registered mail. (see Appendix C).

Step 7: Ultimate refusal will result in referral of Children's Aid Society.

NOTE

- A definite contact must be made with the parent at each step of the protocol. It would be necessary, for example, to make sure that the parent received the initial parent notification and subsequent follow-up before forwarding a request to the nursing department for an appropriate public health nurse follow-up. If phone contact is made with the family, details of the call must be recorded - date, time, who, what was said, etc....

- A mechanism presently exists under the General Welfare Special Assistance system whereby required treatment can be funded for low income families. Local arrangements should be developed between the Health Unit and the local welfare funding agency to clarify their requirements and to work out an efficient method for processing qualifying families.

FOLLOW-UP PROTOCOL FOR PUBLIC HEALTH IDENTIFIED CHILDREN

Immediate/Acute Cases

STEPS	PERSONNEL
1. Primary identification	dental health educator (elementary) public health nurse (secondary) dental hygienist (elementary) classroom teacher
2. Technical assessment	dental hygienist (dental director/dentist)
3. Initial parent notification	same day telephone notification and/or mail
4. Parent follow-up	within 7 days by dental personnel
5. Second parent follow-up	public health nurse
6. Reassessment	dental director/dentist
7. Final disposition (2 weeks)	Children's Aid Society

COMMENTS

Steps 1 - 7: Refer to urgent cases.

D R A F T - (SAMPLE) APPENDIX A DATE

STUDENT'S NAME: _____ SCHOOL/GRADE: _____

ADDRESS: _____ TELEPHONE: _____

Dear Parent/Guardian:

In the course of the school health programme an urgent dental condition was noted. According to procedures recommended by the Ministry of Health and the dental profession, this treatment should be initiated within two months in view of the requirements of the Child and Family Services Act.

The Health Unit asks that you leave the bottom portion of this notification with your dentist when treatment is provided. It will then be returned to our office to indicate that the necessary treatment has been initiated and our records can be updated. When contacting your dentist, please indicate that you received this request so that your child can be quickly seen.

If you have trouble finding a dentist or have any further questions, please contact the Health Unit immediately.

Yours truly

Dental Division
Dental Director

STUDENT'S NAME: _____ SCHOOL/GRADE: _____

ADDRESS: _____ TELEPHONE: _____

Dear Dental Practitioner:

On initiation of treatment for the above child, please sign and return to the health unit.

The above has been to my office and will be treated.

Yours truly,

_____ _____

DATE SIGNATURE

_____

PLEASE PRINT NAME

Please return this form to our office as soon as possible.

D R A F T - (SAMPLE) APPENDIX B DATE

STUDENT'S NAME: _____ SCHOOL/GRADE: _____

ADDRESS: _____ TELEPHONE: _____

Dear Parent/Guardian:

In the course of the school health programme, an acute dental condition was noted. According to procedures recommended by the Ministry of Health and the dental profession, this treatment should be initiated within seven days in view of the requirements of the Child and Family Services Act.

The Health Unit asks that you leave the bottom portion of this notification with your dentist when treatment is provided. It will then be returned to our office to indicate that the necessary treatment has been initiated and our records can be updated. When contacting your dentist, please indicate that you received this request so that your child can be quickly seen.

If you have any trouble finding a dentist or have any other concerns, please contact the Health Unit immediately.

Yours truly,

Dental Division
Dental Director

STUDENT'S NAME: _____ SCHOOL/GRADE: _____

ADDRESS: _____ TELEPHONE: _____

Dear Dental Practitioner:

On initiation of treatment for the above child, please sign and return to the Health Unit.

The above has been to my office and will be treated.

Yours truly,

_____ _____

DATE SIGNATURE

_____

PLEASE PRINT NAME

Please phone within 24 hours and return completed form to our office as soon as possible.

D R A F T - (SAMPLE) APPENDIX C DATE

CHILD'S NAME: _____ AGE: ____

ADDRESS: _____ SCHOOL: _____

RE: NEED FOR IMMEDIATE DENTAL TREATMENT

During the course of our regular dental health screening program _____, a Health Unit Dental Hygienist, found a dental condition that required the professional services of a dentist. We have contacted you by a letter sent home with _____ from school and by phone/letter on the following occasions:

_____.

In these cases our staff are legally required to report their concerns following guidelines established by the Ministry of Health and the Ministry of Community and Social Services.

As of this date, to the best of our knowledge, the urgent conditions which have been reported and verified have not been treated. This letter is our final attempt to encourage a visit to a dentist of your choice. Otherwise, unless we hear from you within _____ days, we are compelled by the Child and Family Services Act to refer this case to the Family and Children's Services.

Please understand that we are motivated by a sincere concern for your child's well-being and that our actions have been taken for this reason as well as to satisfy the legal requirements of the Child and Family Service Act.

Sincerely,

Dental Director

DRAFT - (SAMPLE) APPENDIX D

Suggested Guidelines for Reporting Suspected Cases of Child Neglect/Abuse (Dental) to the Public Health Nursing Department

---

1. Referral Protocol

The Dental Department refers the child needing dental treatment to the Director of Public Health Nursing.

The referral contains:

- identifying information
- reason for referral
- what is expected of nurse
- whether family knows about referral
- time limits
- return report - YES NO
- name of person/department making referral

2. Public Health Nurse Visit

The Public Health Nurse visits the family to identify the problem and helps the parents resolve it. For example - her intervention may include a referral to an appropriate agency to alleviate a financial problem.

3. Resolution of the Problem

(a) If the problem is resolved, the P.H.N. reports findings to the Dental Department, and referral is completed.

(b) If the family is willing to act, but the P.H.N. has been unable to find financial resources, she informs the Dental Department who then take responsibility for the situation.

(c) If the barriers have been removed and all attempts have been made to overcome the problem and it is still unresolved within a time period; i.e. the parents have still not seen that the child receives the recommended dental care; the P.H.N. reports the fact immediately to the Dental Department.

ORAL CONDITIONS RENDERING A CHILD IN NEED OF PROTECTION

A child would be in need of protection if there was failure on the part of the parent or guardian to remedy these oral conditions after having been informed of these conditions.

THESE CONDITIONS INCLUDE:

1. Immediate (acute) need for care due to:

   a) Pain - conditions which are presently causing pain or have caused pain frequently in the time period immediately preceeding assessment.

   b) Infection -

      1) visually apparent abscesses and reports of abscesses or swellings.

      2) gingival conditions (acute) requiring immediate attention such as necrotizing ulcerative gingivitis and any suppurative gingival conditions that would cause abnormal or extreme gingival conditions.

   c) Haemorrhage - most haemorrhage from gingival conditions would be reported under infection. Haemorrhage may also occur from trauma or accidents or subsequent to dental surgery.

   d) Trauma - to premaxilla, maxillae and/or mandible area which does or may affect the teeth and supporting structures including crucial primary teeth.

e) Pathology - any specific pathological condition of the hard or soft tissues where further investigation is recommended and developmental anomalies or pathology of potentially serious nature.

2. Urgent need for care due to:

Conditions which would lead to pain, infection or haemorrhage such as:

a) CARIES

1. In Permanent teeth

2. Primary teeth - lesions in crucial primary teeth

b) PERIODONTAL DISEASE

- periodontal disease which is not reversible by adequate oral hygiene.

ATTACHMENT #3

ONTARIO SOCIETY OF PUBLIC HEALTH DENTISTS

DRAFT
FOR DISCUSSION PURPOSES ONLY

DENTAL CARE PROGRAM
FOR TARGETTED CHILDREN
IN ONTARIO

Prepared by:

Dental Treatment Committee
Ontario Society of Public
Health Dentists

April 9, 1985

CHILDREN'S DENTAL CARE - ONTARIO

INTRODUCTION:

There are children in Ontario who do not receive basic dental health services. Experience over the past two years in Health Units providing Screening, Referral, Follow-up and Survey Programs has shown that although this group of children may represent a small proportion of the total child population, it is extremely difficult and often impossible for the family to make arrangements for basic dental treatment. In most cases, the restrictive factor is lack of discretionary funds.

For a variety of reasons the dental disease rates of Ontario children are the lowest in Canada. This, along with better access to care, significant coverage by third party agencies (about 60 - 65%) and general affluence means that this province may not need to implement a large scale, all inclusive child denticare program in order to resolve the urgent and acute problems seen in a small percentage of children.

MAJOR OPTIONS:

There are two basic options under which child dental services could be introduced:

(1) Universal
(2) Targetted

Universal:

There are economic, philosophic and political arguments both in support of and in opposition to a universal children's dental care program. Indeed, in other times the provision of universal denticare may have been realized. With respect to the 1980's, and the serious restraints being exercised by all levels of government, it would seem that the universal option would not be viable. A good first step would consist of an organized process which would ensure that all Ontario children had reasonable access to basic dental care.

Targetted:

A targetted program would most efficiently utilize scarce financial resources and still ensure an adequate level of dental care for all children. Eligible children would be those:

- with acute/urgent conditions,
- from marginal income families,

- within the eligible age range, and
- not presently covered by Family Benefits or private dental insurance.

POPULATION ESTIMATES AND COST ESTIMATES:

Experience by those Health Unit Dental Divisions providing referral and follow-up services according to procedures recommended by the Ministry of Health, indicate that somewhere between 2% and 4% of the child population present both with acute/urgent dental conditions and a family inability to pay.

It is our assumption, therefore, primarily based on program experience, that about 3% of children are at risk. Since there are roughly 2,125,000 children between the ages of 0 and 16, inclusive, we estimate that 63,750 children need assistance through some organized measure.

However, since there is currently no mechanism to identify these children in the secondary school system, it is proposed that the program initially cover ages 0-13 with one age group added each succeeding year until 0-16 year olds are covered.

It is estimated that utilization of children ages 0-4 would be 25% (due to the minimal treatment requirements of this age group) and ages 5-13 would be at least 90% (because of the follow-up procedures). Ages 14-16 would be no higher than 60% (because of non-screening and voluntary utilization).

Incrementally, the program would result in the following numbers and overall cost using an average individual treatment cost of $200 and $300 per child. The lower range would limit treatment to the specific acute/urgent conditions only, whereas the $300 estimate would include examination, radiographic and other basic elective procedures which most children would also require (i.e., treatment of incipient lesions). The latter fee is more realistic for a private practice referral system where the practitioner is required to examine and radiograph and recognize the preventive philosophy of treating lesions while still quite small.

Year	Numbers	Ages	Cost	
			$200	$300
1	33,187	0-13	6,637,400	9,956,100
2	35,437	0-14	7,087,400	10,631,100
3	37,687	0-15	7,537,400	11,306,100
4	39,937	0-16	7,987,400	11,981,100

The costs are based on constant 1985 dollars and do not reflect the diminished costs per patient which would accrue for maintenance treatment following the initial treatment series.

PROGRAM DESIGN:

1. Patient identification - Through public health screening programs (all 5,7,9,11, and 13 year olds), or on parent request for eligible children in respect to the program year of the Plan.

   - follow-up and prevention conducted by Health Unit according to present recommended procedures.

   - if the family states there is a financial problem, they are referred for a means test. This assessment could be done by:

     (1) Local Social Services Agency
     (2) Health Unit using Social Services criteria and guidance.

2. Treatment - By referral to private practitioners or to public health clinics where available. A Treatment Card to be issued which will be:

   a) valid for 4 months, or
   b) until completion of current treatment needs

   The Card is to be surrendered upon completion of treatment, by the dentist with the final statement to the third party agency.

   In subsequent years, patient is screened annually by Health Unit, in view of "high risk" status. Eligibilit for referral is continued, if treatment needs present and patient's family signs a declaration stating that their financial position has not improved since last assessment.

3. Funding - In either payment option, 100% for approved treatment services by the Ministry of Health (refer to Appendix).

4. Payment Options

   (1) Mechanism operated by a third party agency (similar to the present O.D.A. - COMSOC agreement) on a negotiated fee schedule.

   (2) 100% to Health Unit including treatment clinics (at cost).

Option 1: Once treatment has been approved by the Health Unit Dental Division (verified acute/urgent needs and income level), the private dentist would provide the basic approved services and submit the claim to the third party agency for payment. The third party would receive a negotiated administrative fee. Health Units providing the service would submit a statement to the third party agency based on their "usual and customary" costs, and not to exceed an approved fee schedule.

Option 2: Each Dental Division would be granted appropriate funds to cover the cost of basic services for qualified children through private practitioners. The Unit would submit an annual budget to cover estimated needs for each year.

Health Units directly providing these services in their own clinics would receive funds estimated to provide basic approved services to qualifying children based on their "usual and customary" costs.

5. Preventive Services - Provided to these targetted children by Health Unit staff as part of the Topical Fluoride/Oral Hygiene Program mandated by the Health Protection & Promotion Act. In addition, this service should be enhanced by an educational component directed to the patient's parent(s), so as to maintain the investment in the child's dental health.

6. Secondary School Students - By parental request for re-examination and who had previously qualified within designated age categories and continuing to meet dental and financial criteria. They would be issued identification allowing an annual dental visit to a dentist of choice. The dentist would provide basic approved treatment services. The patient's family would sign a declaration stating that their financial position has not improved since assessment.

   As well, information would be displayed in secondary schools advising students of the availability of assistance if required.

7. Dental Coach Services - The importance of increased utilization of the private practitioner is recognized. It is also recognized that this program would be closely integrated with the Ministry of Health Dental Coach services, and may lead to a reduction of these services in certain areas of the province. The Underserviced Area Program Unit of the Ministry of Health is currently formulating plans in this direction.

APPENDIX

APPROVED SERVICES

EXAMINATION

Complete oral examination - 1/12 month period
Emergency examination
Bitewing x-ray examination - 1/12 month period
Intra-oral x-ray examination - as required

RESTORATIVE SERVICES

Amalgam restorations
Composite/silicate restorations
Stainless steel crowns
Polycarbonate crowns
Retentive pins

ENDODONTIC SERVICES

Pulp capping
Pulpotomy
Root Canal Therapy

SURGICAL SERVICES

Removal of erupted teeth
Surgical removal
Removal of residual roots

ATTACHMENT #4

ONTARIO REGULATION 516/84

under the Health Protection and Promotion Act, 1983

SCHOOL HEALTH SERVICES AND PROGRAMS

1. The health programs and services set out in Column 1 of the Table are prescribed for the purposes of subsection 6 (1) of the Act for the classification of pupils set out opposite thereto in Column 2 of the Table.

TABLE

Item	Column 1 Health Programs and Services	Column 2 Classification of Pupils
1.	A health review consisting of, (a) the taking of a pupil's health and immunization history from the pupil's parent or guardian; (b) the provision of vision and hearing tests for ascertaining visual and hearing acuity; and (c) the observing and recording of any observable abnormalities.	Pupils entering school for the first time.
2.	Advice to a parent or guardian of a pupil to consult a family physician, optometrist, ophthalmologist, otorhinolaryngologist, or audiologist.	Pupil referred to in item 1 who has been identified as having a problem related to health.
3.	Two vision screening tests in addition to those given under item 1 for the early identification of vision defects.	Pupils between grades 3 and 8 or pupils between 8 and 13 years of age with a minimum of three years between the second and third vision screening tests.
4.	Advice to a parent or guardian of a pupil to consult a family physician, optometrist or ophthalmologist.	Pupil referred to in item 3 who has been identified as having a possible vision defect.
5.	Hearing test in addition to that given under item 1 for the early identification of hearing defects.	Pupils in grade 2 or in their second year of school.
6.	Advice to a parent or guardian of a pupil to consult a family physician, otorhinolaryngologist or audiologist.	Pupil referred to in item 5 who has been identified as having a possible hearing defect.
7.	Counselling services on health related problems.	Pupils in elementary and secondary schools.
8.	The provision of professional staff and information on health education.	Pupils in elementary and secondary schools.
9.	Assessment of immunization status.	Pupils entering school for the first time in Ontario.
10.	The provision of immunization for designated diseases within the meaning of the *Immunization of School Pupils Act, 1982*	Pupils who enter school for the first time in Ontario who have not been immunized in accordance with the requirements of the *Immunization of School Pupils Act, 1982* and the regulations there-
11.	Fluoride Program (i.e. a fluoride mouth rinse program that is done weekly or every other week in the school or the provision of daily fluoride tablets or supplements)	Pupils from grade 1 to grade 8 in schools in locations where the level of fluoride in the water system is below 0.7 parts per million.
12.	Dental screening examinations (i.e. examination of the teeth and the tissue of the oral cavity)	Pupils 5, 7, 9, 11 and 13 years of age.
13.	Advice to a parent or guardian of a pupil to consult a dentist.	Pupil referred to in item 12 who has been identified as requiring dental treatment.
14.	Individual topical fluoride application including dental health instruction.	Pupils from kindergarten to grade 8 who exhibit high caries activity.
15.	Dental health education program consisting of at least the following: 1. Information on nutrition. 2. Information on good dental habits and the importance of regular dental services. 3. Instruction respecting the cause of dental caries, periodontal disease and the structure and functions of teeth for each grade, each school year for a total of thirty minutes.	Pupils in kindergarten to grade 8.
16.	Instruction on oral hygiene to include but not be limited to toothbrushing, flossing and plaque disclosing.	At least seven sessions between kindergarten and grade 8.
17.	Follow-up on advice given in items 2, 4, 6 and 13 to determine action taken.	Pupil who has been identified as having a health problem.

O. Reg. 516/84, s. 1.

2. It is a requirement for the provision of any health service or treatment under this Regulation that, where a consent is required by law before the service or treatment is given, such consent shall be obtained by the person providing the service. O. Reg. 516/84, s. 2.

3. Each board of health that carries out dental screening examinations referred to in item 12 of the Table shall submit any statistical information on the dental conditions of the children screened to the Ministry. O. Reg. 516/84, s. 3.

SCHEDULE OF BENEFITS AND ALLOWANCES

Eligibility:

An eligible child will have a program claim form (see Attachment #9) authorizing treatment under the plan. Such a child will remain eligible for 6 months following the issuance of the referral form.

Authorized Services - Without Predetermination:

The services listed in Part one of this schedule may be provided without prior authorization.

Services Requiring Predetermination:

The services listed in Part two require predetermination. A request for authorization must be submitted to the health unit on the Standard ODA predetermination form (Attachment #10). The request will be reviewed by a local committee**.

Fee Levels:

Dentists should claim their usual and customary fee. Claims for specific services will be paid up to a limit of 90 percent of the current Suggested Ontario Dental Association Fee Guide for single services and 80 percent of the guide for additional services in the same sextant or quadrant. Health Units may also reimburse dentists at sessional or per diem rates under special arrangements with the health unit.

The limit on fees will be increased to 120 per cent of the general practioners fee for children who are referred by the family dentist to a specialist who renders the care.

**Local Dental Society Advisory Comittee:

The committee will be chaired by the dental director and include at least one representative nominated through the local society, prepared to volunteer service. This committee will periodically review submissions from dentists requesting authority for Services Requiring Predetermination.

Claims Procedure:

Claims for payment must be submitted, on the program claim form, or attached to the form, to the health unit within 6 months of the date of issuance of the form. The claim form should be completed using standard international tooth and procedure codes. Duplicate Claim Forms must be clearly marked "Duplicate".

Additional Information Required on Claim Forms:

In order to ensure identified children are attending and treatment is being completed, the dentist will be required to indicate the child's treatment status according to the following codes:

(to be completed at a later date)

Emergency Services:

If a child presents for emergency care, dentists will provide the services necessary to treat the pain, infection or trauma. Dentists will arrange for reimbursement in their usual and customary manner. If the parent states an inability to pay for the services, the dental office should contact the health unit dental division. If the family is found to be eligible, the health unit will forward the program claim form to the dental office. If additional services listed in the schedule are required, the dentist may then proceed with treatment upon receipt of the claim form.

Claims Forms:

Forms with incorrect, illegible or missing information will be returned for correction. Completed claims and requests for coverage for services requiring predeterminations, and any inquiries should be directed to:

(name and address of health unit's dental director)

PART - 1.

AUTHORIZED SERVICES

WITHOUT PREDETERMINATION

ODA Procedure Code	Service
	DIAGNOSTIC SERVICES
	CLINICAL ORAL EXAMINATION COMPLETE ORAL EXAMINATION
	(a) History, medical and dental (b) Clinical examination of hard and soft tissues including carious lesions, missing teeth, determination of pocket depth and location of periodontal pockets, gingival contours, mobility of teeth, interproximal tooth contact relationships, occlusion of teeth, pulp vitality tests where necessary and any other pertinent factors.
	EXAMINATIONS
	Please note that procedure code 01300 (Emer. Exam.) is the only one that will be covered for oral and maxillofacial surgeons.
01110	Primary Dentition Clinical oral examination as above
01120	Mixed Dentition Clinical oral examination as above
01130	Permanent Dentition Clinical oral examination as above
01200	Recall Oral Examination Examination of hard and soft tisues including checking of occlusion and appliances. (Radiographs at a separate fee and code)
01300	Emergency Examination Examination for any of the following in a specific area; caries, periodontal disease, orthodontic status, or any other pertinent factor **OR**
01400	Specific Oral Area Examination Examination of any of the following in a specific areas; caries, periodontal disease, orthodontic status, or any other pertinent factor

ODA Procedure Code	Service
	RADIOGRAPHS (Radiographic examination and interpretation)
	INTRAORAL FILMS
	(only five periapical films or 02600 authorized in any twelve month period)
02111	Single periapical film
02112	Two periapical films
02113	Three periapical films
02114	Four periapical films
02115	Five periapical films
	(only two posterior bitewing films are authorized every six months)
02141	X-ray Bitewing - single film
02142	Bitewings - two films
	EXTRAORAL FILMS
02600	Panoramic film in place of 5 periapical films.
	PREVENTIVE SERVICES
13600	Caries/trauma/pain control (removal of carious lesions or existing restorations and placement of sedative/protective dressings). Include surface code. (Note 13600 - 7 days must elapse before placement of final restoration)
13401	pit and fissure sealants - first tooth (first & second permanent molars only.
13404	each additional tooth in the same quadrant (first & second permanent molars only)
	RESTORATIVE SERVICES
	Note 1 - Authorized once every six months. No surface can be paid more than once in a six month period.

ODA Procedure Code	Service

Note 2 - Where, at the same sitting, in order to conserve tooth structure, two separate restorations are performed on the same tooth involving a common surface, this should be considered as one restoration when assessing the fee.

Note 3 - In order to be paid for restorations you must include the proper procedure code, international tooth code and the names of the surfaces restored.

Note 4 - For supernumerary tooth, please use tooth code "99".
Quadrants - there are four quadrants (i.e. maxillary and mandibular, right and left, midline to the most posterior tooth) and the maxillary and mandibular anterior segments (i.e. from maxillary cuspid to cuspid, mandibular cuspid to cuspid). Thus there are six "sextants" in determining the reduction of the fee for multiple services.

CODE	AMALGAM, PREFORMED STAINLESS STEEL AND POLYCARBONATE RESTORATIONS
	(a) Primary teeth (maximum allowance per tooth is the fee for four surfaces and 2.0 units of time.)
21101	Amalgam - one surface
21102	Amalgam - two surfaces
21103	Amalgam - three surfaces
21104	Amalgam - four surfaces
21105	Amalgam - five surfaces
	(b) Permanent anterior and bicupid teeth (maximum allowance per tooth is the fee for 4 surfaces and 2.0 units of time).
21211	Amalgam - one surface
21212	Amalgam - two surfaces
21213	Amalgam - three surfaces
21214	Amalgam - four surfaces
21215	Amalgam - five surfaces

ODA Procedure Code	Service
	(c) Permanent molar teeth (maximum allowance per tooth is the fee for 4 surfaces and 2.0 units of time)
21221	Amalgam - one surface
21222	Amalgam - two surfaces
21223	Amalgam - three surfaces
21224	Amalgam - four surfaces
21225	Amalgam - five surfaces
	FULL COVERAGE RESTORATIONS The fee for crowns includes any necessary preparation.
21403	Preformed stainless steel - primary posterior tooth
21413	Preformed stainless steel - permanent posterior tooth.
21421	Preformed polycarbonate crown - primary anterior tooth
	COMPOSITE RESTORATIONS (maximum allowance per tooth is the fee for a Class IV).
23101	*Class I and V *See note 1 under AMALGAM RESTORATIONS
23102	Class III
23103	Class IV
	Composite Restorations Acid Etch Technique (maximum allowance per tooth is the fee for double Class IV)
23111	*composite, acid etch technique - Class I or V *See note 1 under AMALGAM RESTORATIONS
23112	composite, acid etch technique - Class III
23113	composite, acid etch technique - Class IV
23114	composite, acid etch technique, double Class IV (involving mesial, incisal and distal)

ODA Procedure Code	Service
	Composite Restorations (bicuspid teeth only) (maximum allowance per tooth is the fee for four surfaces)
23201	Posteriors, one surface composite
23202	Posteriors, two surfaces, composite
23203	Posteriors, three surfaces, composite
23204	Posteriors, four surfaces, composite
	Composite Restorations **Acid Etch Techniques** (bicuspid teeth only) (maximum allowance per tooth is the fee for four surfaces)
23221	Posteriors, one surface, composite, acid etch technique
23222	Posteriors, two surfaces, composite acid etch technique
23223	Posteriors, three surfaces, composite acid etch technique
23224	Posteriors, four surfaces, composite acid etch technique
	OTHER RESTORATIVE SERVICES
29100	Recement inlays or crowns
29300	Removal of crown or inlay
	ENDODONTIC SERVICES
	PULPOTOMY Notes 1. Vital Permanent Anterior and Bicuspid Teeth Only 2. Not on a Pulpectomy
32201	Vital pulpotomy - permanent anterior or bicuspid
32211	Vital pulpotomy - primary tooth
	ROOT CANAL THERAPY Includes treatment plan, clinical procedures with appropriate radiographs, follow-up care, but excluding final restoration.

ODA Procedure Code	Service
	Notes 1. Clinical procedures are shown following each coded service to facilitate determination of fee for treatment. They should not be itemized on the claim form 2. Where clinical procedures must be REPEATED this should be noted. 3. Permanent Anterior and Bicuspid teeth only 4. Only one of 33100, 33120 and 33501 per tooth allowed. 5. Fee must be modified if one, or more, procedures are eliminated or modified. 6. Submit on claim form at COMPLETION of therapy. 7. If, because of extenuating circumstances, treatment is only partially completed, submit a partial billing and provide details in the "For Dentist's Use Only" section of the claim form.
33100	One canal, fully developed root Pulpectomy - one canal, fully developed root Biomechanical preparation, one canal, fully developed root. Chemotherapeutic treatment or root canal Obturation, one canal, fully developed root
33120	One canal, partially developed root Pulpectomy, one canal, partially developed root Biomechanical preparation, one canal, partially developed root, Chemotherapeutic treatment, one canal, partially developed root, Obturation, one canal, partially developed root
33200	Two canals, fully developed roots Pulpectomy, two canals Biomechanical preparation, two canals, Chemotherapeutic treatment, two canals. Obturation, two canals

ODA Procedure Code	Service
PART I	
33220	Two canals, partially developed roots Pulpectomy, two canals, partially developed roots, Biomechemical preparation, two canals, partially developed roots Chemotherapeutic treatment, two canals partially developed roots Obturation, two canals, partially developed roots
33300	Three canals, fully developed roots Pulpectomy, three canals Biomechanical preparation, three canals Chemotherapeutic treatment , three canals Obturation, three canals
33501	Apexification - one canal Biomechanical preparation of partially developed root, one canal Chemotherapeutic treatment, one canal Obturation, one canal
33502	Apexification - two canals Biomechanical preparation of partially developed root/roots, two canals Chemotherapeutic treatment, one canal Obturation, two canals
33503	Apexification - three canals Biomechanical preparation of partially developed roots, three canals Chemotherapeutic treatment, three canals Obturation, three canals
	Note: Supernumerary tooth Please use tooth code "99"
	TRANSITIONAL PARTIAL DENTURE (Maxillary or Mandibular)
	Diagnostic Services (a) Examination - Refer to Diagnostic Services 01000 Series (b) Radiographs - Refer to 02000 Series

ODA Procedure Code	Service
52120	*Maxillary transitional partial denture -acrylic base
52121	*Mandibular transitional partial denture -acrylic base
	*The terminology - temporary, provisional, thumb plate, flipper, spacer, is often used to describe a transitional partial denture. It is more commonly used to replace anterior teeth.
	DENTURE REPAIRS
	Diagnostic services examination - refer to Diagnostic Services 01400
55101	Repair broken complete maxillary denture no impression required
55102	Repair broken complete mandibular denture, no impression required
55103	Repair broken partial maxillary denture, no impression required
55104	Repair broken partial mandibular denture, no impression required
55201	Repair broken complete maxillary denture, impression required
55202	Repair broken complete mandibular denture, impression required
55203	Repair broken partial maxillary denture, impression required
55204	Repair broken partial mandibular denture, impression required
55520	Maxillary partial denture additions
55530	Mandibular partial denture additions
55700	Denture prophylaxis and polishing

ODA Procedure Code	Service

SURGICAL SERVICES

NOTE: All surgical services are preceded by the appropriate diagnostic services.

Examination - Refer to Diagnostic Services 01000 Series

Radiographs - Refer to 02000 Series

The following surgical services include necessary suturing and one post-operative treatment when required. A surgical site is considered to include a full quadrant; a sextant, or a group of several teeth which can be practically and conveniently combined for a single surgical sitting.

Note: Supernumerary Tooth
Please Use Tooth Code "99":

REMOVAL OF ERUPTED TOOTH - UNCOMPLICATED

71101	Single tooth (bone contouring included) (1st tooth in surgical site)
71111	Each additional tooth in the same surgical site

SURGICAL REMOVALS

NOTE: An impacted tooth is one which is prevented from its normal path of eruption by hard tissue (tooth or bone).

First tooth in surgical site - Full Fee.
Each additional tooth will be paid at reduced fee (as 71111).
If surgical service on a decidious tooth is required please give an explanation on the claim form.

ODA Procedure Code	Service
72100	Removal of each erupted tooth (complicated)
	REMOVAL OF RESIDUAL ROOTS (The fee allowance is the maximum for the multiple roots of any one tooth)
72310	Roots with soft tissue coverage
	UNCLASSIFIED TREATMENT Local Anaesthesia - not in conjunction with operative or surgical procedures - Refer to Diagnostic Services 01300, 01400
92110	Regional block anaesthesia (not in conjunction with operative or surgical procedures)
92120	Trigeminal division block (not in conjunction with operative or surgical procedures)
	GENERAL ANAESTHESIA
	(Includes pre-anaesthetic evaluation and post-anaesthetic follow-up)
	The elimination of all sensations, accompanied by the loss of consciousness. Also included is "dissociative" anaesthesia (Ketamine)
92201	General anaesthesia - first **unit of time**
92202	Each additional **unit of time**
92215	Provision for additional office support systems required when the anaesthetic service is administered by a separate anaesthetist - per **unit of time**
	NEUROLEPTANALGESIA AND RELATED TECHNIQUES
	Profound analgesia and/or sedation including marked physical and psychic detachment which may involve intermittent periods of unconsciousness.

ODA Procedure Code	Service
	This state is produced by the continuous or intermittent administration of competent drugs in a balanced manner. These techniques must not be confused with a conscious sedation technique.
92251	Neuroleptanalgesia - first **unit of time**
92252	Each additional **unit of time**
	CONSCIOUS SEDATION
	The use of systematic drugs to produce a calm, relaxed comfortable patient without the loss of consciousness.
92310	Conscious sedation - inhalation (nitrous oxide and oxygen) First **unit of time**
92311	Each additional **unit of time**
	PARENTERAL ADMINISTRATION
92330	Conscious sedation - intravenous
92340	Conscious sedation by intramuscular injection of sedative drug
	DRUGS
96100	Therapeutic intramuscular drug injection
96101	Therapeutic intravenous drug injection
	IN-OFFICE LABORATORY SERVICES
99350	In-office laboratory charges

PART - 2.

SERVICES

REQUIRING PREDETERMINATION

CROWNS - SINGLE RESTORATIONS ONLY
PREAMBLE

Guidelines for Procedural Requirements

The following shall be considered necessary to constitute acceptable treatment:

a) Removal of diseased tooth structure.
b) Assessment of the necessity for:
    i) provision of substitute substructure to provide sufficient retention and protection of the remaining natural tooth.
    ii) finishing and contouring of adjacent restorations.
    iii) correction of periodontal abnormalities related to the unit.
    iv) correction of occlusal abnormalities in the opposing arch related to the unit.

Assessment of the necessity for (i), (ii), (iii), (iv) is to be considered part of the prosthodontic treatment. Should any of the above be required then it would be done as a separate entity with the additional fee guided by the appropriate code numbers in the suggested Fee Guide.

c) Design and execution of tooth reduction to accommodate the dictates of the chosen restorative material and the functional requirements (occlusal and retentive).
d) Accurate impressions of the prepared tooth, its surroundings and opposing occlusion.
e) Accurate centric registration as a minimum in occlusal registration.
f) Adequate provisional coverage for the treated tooth for the interim of the treatment period.
    Adequate coverage shall mean:
    i) protection of the cut dentinal tubules and underlying dental pulp.
    ii) maintenance of contact to adjacent teeth.
    iii) maintenance of an acceptably stable functional occlusion during the construction period.
    iv) respect for periodontal structures; i.e. the provisional restoration should provide little or no significant insult to the surrounding tissues.
g) Shade selection where necesary.
h) A proper written prescription for the guidance of the dental technician.
i) Proper insertion technique which includes:
    i) pulp protection,

ODA Procedure Code	Service

ii) occlusal and contact adjustments,
iii) marginal fitting and finishing
iv) a cementation technique which reflects the proper choice of cement along with care to cement under the most hygienic and optimum conditions

j) Occlusal adjustment of the finished restoration.

27130	Acrylic (or composite) --transitional, direct (chairside)
27140	Acrylic (or composite) --transitional, indirect
27200	Porcelain
27210	Porcelain fused to metal base (porcelain veneer)
27300	Metal (full cast)
27310	Metal (3/4)
27500	Metal transitional, direct (chairside)
27700	Cast metal post and core as a separate procedure
27701	Cast metal post and core as a separate procedure - 2 sections
27702	Cast metal post and core as a separate procedure - 3 sections
27710	Cast metal post and core concurrent with impression for a crown (when possible)
27711	Cast metal post and core concurrent with impression for a crown (when possible) 2 sections
27712	Cast metal post and core concurrent with impression for a crown (when possible)3 sections
27800	Metal transfer coping (thimble) as a separate procedure
27810	Metal transfer coping (thimble) concurrent with impression for crown (when possible)

PREFABRICATED - precious metal posts or plastic post patterns for castings for reinforcing devitalized teeth.
PREFORMED - manufactured standard or stock posts that are used to reinforce devitalized teeth.
CAST METAL POST AND CORE - custom made castings for reinforcing devitalized teeth.

OTHER RESTORATIVE SERVICES

29501	One retentive preformed post (with or without preformed core)

ODA Procedure Code	Service
PART II	
29502	Two retentive preformed posts
29503	Three retentive preformed posts
29511	One prefabricated metal post and cast core
29512	Two prefabricated metal posts and cast cores
29513	Three prefabricated metal posts and cast cores
29600	Pin-reinforced amalgam post and/or core for crown restoration (materials included)
29610	Pin-reinforced composite post and/or core for crown restoration (materials included)
29700	Crown made to an existing partial denture clasp
29800	Cement restoration

PROSTHODONTIC SERVICES
Prosthodontics - Removable

PREAMBLE

1. This service is the provision of an artificial substitute for living tissue.
2. Professional skill used to provide the method of substitution is the essence of this health service, rather than the artificial component (denture).
3. There are two distinct and identifiable integral components necessary for the provision of this health service:
   (a) Physiological component - requiring professional skill,
   (b) Technical component - requiring laboratory procedures.
4. The significance of this service is in the preservation of the oral tissues supporting the artificial denture.
5. The value of this service is in the replacing of tooth function to the maximum possible range.

The following appendix (parts A and B) on clinical Procedures for Complete and Removable Partial Dentures, and the outlines for prosthetic procedures as related to the Fee Guide are designed to fulfil the principles outlined above. It will be noted therefore:

(a) Diagnostic Services are emphasized by reference to the appropriate diagnostic procedure for each denture service being rendered.

ODA Procedure Code | Service

CLINICAL PROCEDURES FOR COMPLETE AND REMOVABLE PARTIAL DENTURE THERAPY RELATED TO THE SUGGESTED FEE GUIDE

A. COMPLETE DENTURES

1. DIAGNOSTIC PROCEDURES

(a) Examination: Complete oral examination including dental and medical history, psychological considerations, visual and digital clinical examination - refer to 01000 Series

(b) Radiographic examination - refer to 02000 Series

2. IMPRESSIONS

(a) Preliminary impressions

(b) Final impressions

3. JAW RELATION RECORDS

(a) Vertical relations - rest and occlusal vertical dimension

(b) Horizontal relations - centric jaw relation record

(c) Face-bow transfer

(d) Tooth selection - mould and shade

4. TRY-IN

(a) Check records - verification of centric jaw relation record and/or articular mounting.

(b) Remount from new records (if necessary)

(c) Evaluation and modification to anterior tooth arrangement as influenced by aesthetic and phonetic checks

5. INSERTION

(a) Denture base check for pressure spots and base extension

(b) Patient instruction and delivery

6. ADJUSTMENTS

Includes three months post delivery care

7. OCCLUSAL EQUILIBRATION

Remount of dentures for occlusal equilibration

ODA
Procedure Code | Service

B. PARTIAL DENTURES

1. DIAGNOSTIC PROCEDURES
(a) Examination: Complete oral examination including dental and medical history, psychological considerations, visual and digital clinical examination - refer to 01000 Series
(b) Radiographic examination - refer to 02000 Series

2. TREATMENT PLAN
(a) Preliminary impressions (diagnostic casts)
(b) Survey and analysis of diagnostic cast(s)
(c) Selection of design and outline of mouth preparation on diagnostic cast(s)
(d) Preparation of laboratory prescription.

3. MOUTH PREPARATIONS
(a) Execution of indicated preparation procedures
(b) Final impressions

4. FRAMEWORK TRY-IN
(a) Fitting of framework
(b) Altered cast impression (if free-end extension situation)

5. JAW RELATION RECORDS
(a) Vertical and horizontal relations
(b) Face-bow transfer (if necessary)
(c) Selection of teeth - mould and shade

6. TRY-IN EVALUATION
(a) Check records (remount if necessary)
(b) Evaluation and modification to tooth arrangement

7. INSERTION
(a) Framework/denture base check for pressure spots and base extension
(b) Patient instruction and delivery

ODA Procedure Code | Service

8. ADJUSTMENTS
Includes three months post delivery care.

9. OCCLUSAL EQUILIBRATION
Remount of denture for occlusal equilibration.

This outline lists the treatment procedures in the provision of removable prosthesis.

OVERDENTURES
Refer to appropriate codes for denture services plus such other services and codes as may be necessary for preservation of the alveolar ridge.

51100 **COMPLETE MAXILLARY DENTURE**

1. Diagnostic Services
(a) Examination - Refer to Diagnostic Services 01000 Series
(b) Radiographs - Refer to 02000 Series
2. Impressions
3. Jaw relation records
4. Try-in evaluation and check records
5. Insertion
6. Adjustments (includes three months post insertion care)

51110 **COMPLETE MANDIBULAR DENTURE**

1. Diagnostic Services
(a) Examination - Refer to Diagnostic Services 01000 Series
(b) Radiographs - Refer to 02000 Series
2. Impression - initial and final
3. Jaw relation records

ODA Procedure Code	Service
	4. Try-in evaluation and check records 5. Insertion 6. Adjustments (includes three months post insertion care)
51120	**COMPLETE MAXILLARY AND MANDIBULAR DENTURES** 1. Diagnostic Services (a) Examination - Refer to Diagnostic Services 01000 Series (b) Radiographs - Refer to 02000 Series 2. Impressions - initial and final 3. Jaw relation records 4. Try-in evaluation and check records 5. Insertion 6. Adjustments (includes three months post insertion care)
51300	Immediate complete maxillary denture (including three months post insertion care, including tissue conditioners but does not include permanent reline)
51310	Immediate complete mandibular denture (including three months post insertion care, including tissue conditioners but does not include permanent reline)
51320	Immediate complete maxillary and mandibular dentures (including three months post insertion care, including tissue conditioner but does not include permanent relines)
51600	Transitional (temporary) complete maxillary denture
51610	Transitional (temporary) complete mandibular denture
51620	Transitional (temporary) complete maxillary and mandibular dentures.
	REMOVAL PARTIAL DENTURE (Maxillary or Mandibular)

ODA Procedure Code	Service
	Diagnostic Services (a) Examination - Refer to Diagnostic Services 01000 Series (b) Radiographs - Refer to 02000 Series
52220	Maxillary, acrylic base - with or without wrought clasps
52221	Mandibular, acrylic base - with or without wrought clasps
52230	Maxillary, acrylic base - with gold or chrome clasps with rests
52231	Mandibular, acrylic base - with gold or chrome clasps with rests
52320	Maxillary, wrought bar (palatal) with rests and clasps
52321	Mandibular, wrought bar (lingual) with rests and clasps
	CAST CHROME COBALT (OR GOLD)
52400	Maxillary with chrome cobalt palatal connector, rests, clasps and acrylic base (free end RPD)
52410	Mandibular with chrome cobalt lingual or labial connector, rests, clasps and acrylic base (free-end RPD)
52500	Maxillary with palatal connector, rests, clasps and cast chrome cobalt base (tooth-borne)
52510	Mandibular with lingual connector, rests, clasps and cast chrome cobalt base (tooth-borne)
52520	Maxillary and Mandibular RPD

ODA Procedure Code	Service
52525	For each altered cast impression technique when done in conjunction with Codes 52520, 52400, 52410, add
52530	Maxillary complete denture with mandibular removable partial denture - case chrome cobalt lingual connector, rests clasps and acrylic base
52531	Mandibular complete denture with maxillary removable partial denture - cast chrome cobalt palatal connector, rests, clasps and acrylic base
52535	For altered cast impression technique when done in conjunction with Codes 52530, 52531, add

PROSTHODONTIC SERVICES
PROSTHODONTICS - FIXED

PREAMBLE

A. AIMS OF FIXED PROSTHODONTIC SERVICES

1.) The restoration of diseased or missing teeth or parts of teeth.

2.) The maintenance of the restored teeth and their surrounding supporting structures in a normal healthy condition for as long a time as possible.

3.) The prevention of further injury to the restored teeth.

4.) The correction of abnormal oral conditions whether they be cosmetic, functional (occlusal) and/or periodontal (as in periodontal prosthetics).

B. EXTENSIVE OR COMPLICATED RESTORATIVE DENTISTRY

In order to qualify as "extensive or complicated restorative dentisty" a restorative treatment plan should include or encompass some or all of the following considerations:

1.) Multiple units in opposing quadrants.

2.) Major changes in the occlusal plane.

3.) The opening or closing of vertical dimension with fixed restorations.

4.) Repositioning of the mandible; i.e. a correction of the acquired occlusion to centric relation by means of fixed restorations.

5.) Bridgework of three abutments or more which begins in one posterior quadrant and ends in the anterior segment or in the opposite posterior quadrant.

6.) Development of major changes in incisal guidance.

7.) Development of major changes in occlusal morphology.

8.) Extensive splinting of mobile teeth.

9.) Major restorative dentistry for treatment of temporomandibular joint and myo-facial pain syndrome.

C. GUIDELINES FOR PROCEDURAL REQUIREMENTS FOR FIXED PROSTHODONTIC SERVICES

1.) Procedural requirements for three to four unit fixed prosthesis and multiple adjacent units.

The following requirements shall be considered necessary to constitute acceptable treatment.

a) The same requirments as those for a single unit (refer to CROWNS - Preamble) with the addition of:

b) Centric and eccentric occlusal records and the programming of a semi-adjustable articulator or the use of a functionally generated path technique.

c) Abutment design, preparation and retainer construction in a manner compensating for the additional stress on the prosthesis.

d) Paralleling of the abutments or the judicious use of broken stress principles when necessary. (Broken stress techniques may have to be at an additional fee).

e) Assessment of the necessity for:

i) occlusal correction of a total quadrant or total mouth
occlusal correction as opposed to correction of one or two opposing teeth as in the single unit.

ii) correction of tissue around <u>all</u> abutments and <u>ridge area</u> for proper pontic design.

iii) complete mouth periodontal treatment.

f) Design of pontics and the total prosthesis to provide sufficient strength to resist moments of bending and to provide acceptable cosmetic appearance, function and protection of the surrounding tissues.

g) Provisional restoration in accordance with requirements for single restorations and in

C. **GUIDELINES FOR PROCEDURAL REQUIREMENTS FOR FIXED PROSTHODONTIC SERVICES - CONT.**

addition, the requirement to maintain abutment relationships through the provision of pontics and the restoration of proximal contact.

h) Diagnostic casts, refer to Codes 04510 or 04520

i) Complete series periapical films - refer to Code 02100

ODA Procedure Code	Service
	PONTICS
62500	Porcelain fused to metal pontic
	RETAINERS
65500	Metal overlay acid etch bonded - per abutment tooth - (pontics extra) (Maryland, Rochette or others)
	SURGICAL REMOVALS
	NOTE: An impacted tooth is one which is prevented from its normal path of eruption by hard tissue (tooth or bone).
	First tooth in surgical site - Full Fee. Each additional tooth will be paid at reduced fee (as 71111). **If surgical service on a decidious tooth is required please give an explanation on the claim form.**
72210	Removal of each tooth - soft tissue coverage
72220	Removal of each impacted tooth - partial bony impaction
72230	Removal of each impacted tooth - complete bony impaction
72240	Removal of each impacted tooth - unusual position or age factor (including supernumerary)
	REMOVAL OF RESIDUAL ROOTS (The fee allowance is the maximum for the multiple roots of any one tooth)
72320	Roots with bone tissue coverage

ATTACHMENT #6 (a)

ROLAND W.K. DOBSON
ADMINISTRATOR
ADMINISTRATION CENTRE
MIDHURST LOLIXO

TELEPHONE 705-726-9300
BEETON AREA - 729-2294
MIDLAND AREA - 526-2261
ORILLIA AREA - 326-7397
STAYNER AREA - 428-3143
COLDWATER - ZENITH15420

COUNTY OF SIMCOE SOCIAL SERVICES DEPARTMENT

September 9, 1985

Dr. Terry Hicks
Director
Dental Division
Simcoe County and District
Health Unit
Administration Centre
Midhurst, Ontario
L0L 1X0

Dear Dr. Hicks:

Further to our recent communication, with regard to the cost of dental treatment for children from low income families who have serious or acute dental conditions; please be advised that we have completed a survey of fifteen of the most recent cases and have established that the average cost is $276.00 per child.

Should you have any further questions, please do not hesitate to contact me.

Yours truly,

R.W.K. Dobson
Administrator

RWKD:gb

ATTACHMENT #6 (b)

Simcoe County District Health Unit

County Administration Centre, Midhurst, Ontario L0L 1X0 (705) 726-0100

September 24, 1986

Dr. R.K. Ryan, Senior Dental Consultant
Ministry of Health
Public Health Branch
Fifth Floor
15 Overlea Blvd.
Toronto, Ontario
M4H 1A9

RE: COSTS OF BASIC DENTAL CARE

Dear Dr. Ryan:

Once again our local Social Services have indicated that their funds for dental care for our immediate and urgent referrals are depleted. We will be requesting that additional funds are allocated presuming some form of provincial plan in 1987. As you know monies for dental care come out of their Special Assistance Budget which is composed of 50% federal and 50% local tax dollars.

Incidentally, the average cost of treatment for all children funded in 1986 by Social Services is something around $340.00. This should be fairly representative of the province because the dentist is allowed to complete all basic care, excepting preventive, and I suspect Simcoe County dental fees are pretty well in line with any other area.

Yours sincerely,

Dr. T.W. Hicks, D.D.S., D.D.P.H.
Director of Dental Services

TWH:wb

Copy to: Mr. R. Dobson

ATTACHMENT #6 (c)

C. R. COTTON
Secretary-Treasurer
and
Business Administrator

DR P. J. HALKET, M.D., D.P.H.
Director and
Medical Officer of Health

HASTINGS AND PRINCE EDWARD COUNTIES HEALTH UNIT

179 NORTH PARK STREET
BELLEVILLE, ONTARIO
K8P 4P1
(613) 966-5500

87/02/17

Dr. R.K. Ryan
Senior Dental Consultant
Public Health Branch
Ministry of Health
15 Overlea Blvd., 5th Floor
TORONTO, Ontario M4H 1A9

Dear Dr. Ryan:

RE: Dental Treatment Costs,
Acute Cases

During the 1985/86 school year, our dental screening program identified 236 children in "acute" condition.

From this pool, 25 cases were randomly selected with a view to estimating the average treatment costs to return these children to a state of dental fitness.

For this estimation, the following parameters were utilized:

- 1986 O.D.A. Suggested Fee Schedule
- complete oral examination,
  primary dentition @ $31.00
  mixed dentition @ $47.00
- radiographs @ $35.00
- restorations, amalgam
  primary molars to 9 years @ $40.00
  permanent bicuspids @ $40.00
  permanent molars @ $46.00
  permanent molars, large caries @ $52.00

- restorations, composite
  permanent anteriors @ $52.00

- crown loss, consider as extraction @ $31.00
- sealants, not included

The resultant estimations were as follows:

- medium $298.92
- range, high $546.00
  low $134.00

I trust this information is helpful.

Yours sincerely,

Dennis A. Warrick, D.D.S., D.D.P.H.
Director, Dental Services

ATTACHMENT #6 (d)

A COST SURVEY
OF A
GOVERNMENT SPONSORED
SCHOOL BASED
CHILDREN'S DENTAL TREATMENT PROGRAM
IN
NORTHWESTERN ONTARIO

PREPARED BY:
DR. L.W. ARMSTRONG & STAFF
JANUARY, 1987

INTRODUCTION

The purpose of this survey was to determine the continuing costs of providing dental treatment for children with generally high caries experience.

Since many of the children in the Ministry's Northwestern Health Unit program have high caries rates, it was felt that information from this program would be helpful in determining future costs of a dental program for targeted children in the province. Of special interest was the cost of providing treatment to children who were in their second and third years of such a program.

METHOD

The dental treatment records for all children, who had received treatment in the program since it began in 1980, were reviewed to determine which children should be included in the survey. Children who satisfied the following criteria were selected:

1) decay present in three or more permanent teeth; or decay present in crucial primary teeth, at the initial visit to the program;
2) treatment provided in at least two consecutive years, with evidence that treatment was completed within each year, ie treatment rendered corresponded to treatment plan.

The following information was taken from the records of the children selected and placed in lists according to the school they attended;

1) Age of the child on the initial visit;
2) Costs of the services provided, excluding preventive, but including diagnostic, for each year the child was in the program, up to a maximum of three years. Costs were determined according to the 1986 ODA Fee Guide.

RESULTS

Total number of school sites: 6 (1 school site excluded in final assessment since there was no second year information).
Total number of children included in the survey: 98

COSTS OF PROVIDING DENTAL TREATMENT
(1986 ODA FEE GUIDE)

	YEAR I	YEAR II	YEAR III
TOTAL	$40,976.00	$9,420.00	$4,353.00
AVERAGE PER CHILD	$ 418.12	$ 96.12	$ 56.53

DISCUSSION

The results of this survey would suggest a dramatic reduction in the costs of providing treatment in the second and third years of a program aimed at children with high dental caries experience. (1st year: $418.12, 2nd year $96.12, 3rd year $56.53)

Even in the two schools with the highest first year costs: Hudson ($548.43) and Wabigoon ($456.78), the second and third year costs were significantly less: Hudson ($80.21 & $42.50) and Wabigoon ($87.69 & $41.58).

The children in the treatment program receive their preventive services through the health unit's school prevention program. This would include one to one oral hygiene instruction, plus topical fluoride application as well as weekly fluoride rinse and school dental health education.

Sealants were not generally provided during the earlier stages of the treatment program. This is however a preventive service that is now regularly provided by the program dentists. Maintenance costs may therefore be somewhat elevated, compared to previous years when this service was not provided.

It should also be noted that space maintenance in the program is provided by chairside constructed band-loop space maintainers. Since there are no lab costs and the material costs are minimal, the overall costs for providing space maintence is very little. However, private dentists may insist on using lab-prepared space-maintainers with considerably greater costs. This would obviously result in higher average cost per child.

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
HUDSON	12	$ 324.00	$ 30.00	$ -
	7	549.00	168.00	16.00
	7	214.00	96.00	89.00
	11	387.00	72.00	16.00
	10	515.00	30.00	16.00
	10	230.00	16.00	30.00
	9	423.00	30.00	16.00
	10	512.00	51.00	16.00
	9	622.00	102.00	68.00
	8	387.00	96.00	16.00
	10	477.00	30.00	16.00
	7	488.00	61.00	16.00
	5	476.00	16.00	226.00
	8	276.00	197.00	145.00
	7	629.00	165.00	16.00
	7	765.00	181.00	16.00
	7	1274.00	160.00	16.00
	7	1083.00	104.00	16.00
	6	646.00	16.00	68.00
	8	343.00	30.00	16.00
	7	363.00	68.00	-
	6	1102.00	30.00	-
	8	529.00	96.00	16.00
	Total Kids 23	$12614.00	$1845.00	$850.00
	Average	548.43	80.21	42.50

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
STURGEON CREEK	11	$ 165.00	$ 129.00	$ 30.00
	10	292.00	30.00	108.00
	11	191.00	67.00	56.00
	11	263.00	229.00	41.00
	Total kids 4	$ 911.00	$ 455.00	$ 235.00
	Average	$ 227.75	$ 113.75	$ 58.75
McCROSS 'N TOVELL	11	415.00	145.00	-
	9	411	93.00	108.00
	11	203.00	438.00	-
	11	385.00	155.00	-
	9	379.00	195.00	103.00
	9	249.00	181.00	-
	9	415.00	61.00	56.00
	9	332.00	128.00	-
	9	527.00	108.00	-
	Total kids 9	$3,316.00	$1504.00	$ 267.00
	Average	$ 368.44	$ 167.11	$ 89.00

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
LILLIAN BERG	10	$ 207.00	$ 102.00	$ 89.00
	11	222.00	269.00	-
	11	534.00	188.00	41.00
	5	261.00	60.00	235.00
	10	217.00	30.00	30.00
	12	437.00	16.00	-
	8	175.00	113.00	56.00
	9	437.00	30.00	30.00
	7	159.00	170.00	89.00
	6	319.00	30.00	118.00
	7	412.00	134.00	41.00
	6	427.00	30.00	58.00
	13	340.00	174.00	42.00
	5	468.00	61.00	16.00
	5	327.00	174.00	89.00
	6	497.00	134.00	16.00
	9	467.00	30.00	108.00
	7	880.00	41.00	74.00
	11	362.00	260.00	30.00
	5	242.00	76.00	-
	7	298.00	105.00	16.00
	5	710.00	180.00	-
	Total Kids 22	$8,398.00	$2407.00	$ 1178.00
	Average	$ 381.72	$ 109.40	$ 65.44

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
DONALD YOUNG	12	$ 305.00	$ 174.00	$ -
	11	134.00	108.00	145.00
	11	352.00	51.00	134.00
	10	160.00	27.00	72.00
	11	181.00	129.00	108.00
	9	186.00	93.00	113.00
	11	316.00	51.00	30.00
	11	337.00	30.00	-
	10	522.00	30.00	30.00
	11	191.00	30.00	134.00
	8	526.00	144.00	30.00
	9	282.00	114.00	30.00
	7	674.00	93.00	102.00
	5	605.00	30.00	16.00
	5	256.00	30.00	138.00
	6	607.00	56.00	-
	6	508.00	457.00	186.00
	Total kids 17	$6,142.00	$1647.00	$1268.00
	Average	$ 361.29	$ 96.88	$ 90.57

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
WABIGOON	9	$723.00	$ 41.00	$ 41.00
	12	291.00	82.00	-
	12	337.00	82.00	-
	10	659.00	30.00	-
	6	384.00	27.00	205.00
	7	683.00	30.00	51.00
	6	398.00	245.00	16.00
	6	453.00	30.00	30.00
	10	259.00	114.00	16.00
	11	223.00	98.00	16.00
	9	546.00	30.00	68.00
	10	580.00	134.00	16.00
	8	668.00	30.00	30.00
	8	370.00	108.00	110.00
	9	442.00	98.00	16.00
	11	458.00	200.00	16.00
	11	224.00	109.00	30.00
	9	432.00	68.00	37.00
	8	562.00	190.00	30.00
	8	593.00	82.00	16.00
	7	495.00	45.00	30.00
	11	310.00	72.00	-
	12	416.00	72.00	16.00
	Total kids 23 Average	$10,506.00 $ 456.78	$2017.00 $ 87.69	$ 790.00 $ 41.58

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
PINEWOOD	13	$ 591.00	$ -	$ -
	13	648.00	-	-
	13	456.00	-	-
	17 *Gr. 8	492.00	-	-
	12	311.00	-	-
	13	337.00	-	-
	13	223.00	-	-
	12	150.00	-	-
	13	254.00	-	-
	13	512.00	-	-
	8	274.00	-	-
	6	245.00	-	-
	4	262.00	-	-
	5	725.00	-	-
	9	593.00	-	-
	6	247.00	-	-
	8	269.00	-	-
	6	245.00	-	-
	6	479.00	-	-
	7	419.00	-	-
	11	176.00	-	-
	8	273.00	-	-
	7	356.00	-	-
	10	316.00	-	-
	6	605.00	-	-

SCHOOL	AGE AT INITIAL APPOINTMENT	TREATMENT REQUIRED IN DOLLARS (1986 FEE GUIDE)		
		YEAR 1	YEAR 2	YEAR 3
PINEWOOD	7	$ 488.00	$ -	$ -
	5	445.00	-	-
	4	462.00	-	-
	5	696.00	-	-
	12	207.00	-	-
	Total kids 30	$11,757.00	-	-
	Average	$ 391.90		

DERIVATION OF COST ESTIMATES FOR MAINTENANCE CARE IN YEARS 2 and 3

The Committee assumed that this group of children would have a high incidence of caries. To find a similar group, the experience of the treatment provided to children in the CU&C plan (attachment #7c) was examined along with that of the experience of the children in the Saskatchewan Health Plan (attachment #7b) and that in Kenora (attachment #6d). The costs of the services were compared as if they had been paid using 1986 ODA fees and are as follows:

COSTS	SOURCE
114.52	CU&C aged 5-9
150.05	CU&C aged 10-14
92.68	Saskatchewan Dental Plan
92.89	" "
75.05	" "
64.79	" "
74.35	" "
92.12	Kenora Year 2
56.53	Kenora Year 3

The Committee felt that, in the second year (the first maintenance year) the children would not necessarily have their occurrence of new caries as limited as they would in subsequent years. Thus they selected the 5-9 year olds in the B.C. experience as most probable and chose $115 per child as the cost estimate for this first maintenance year.

For the second maintenance year the Committee decided to drop the two extreme values (150.05 CU&C - 56.53 Kenora) and average the other 7 pieces of data. This resulted in a cost estimate of $87 per child.

ATTACHMENT #7(b)

SASKATCHEWAN HEALTH DENTAL PLAN

MAINTENANCE CARE PROVIDED 1984/85

NUMBER OF SERVICES PER 100 CHILDREN

Year of Birth	1978	1977	1975	1973	1971	
Age	6-7	7-8	9-10	12-13	14-15	
Number of Children	13,825	14,100	13,544	12,897	12,969	
Services (per 100):						ODA Fee:
Amalgams	110.2	116.4	87.9	69.9	96.8	46.94
Composites	1.8	2.8	5.8	8.9	13.2	32.19
Crowns (SS)	16.0	13.2	5.3	0.9	0.1	80.48
Temporaries	2.1	1.3	1.5	1.4	0.7	26.83
Pulpotomy	11.5	8.8	4.7	1.1	0.4	26.83
Extractions	11.3	12.0	12.0	13.8	6.4	32.19
Cost (per child):						
Service Cost	72.45	72.73	52.91	41.51	52.13	
Recall Exam	16.10	16.10	16.10	16.10	16.10	
BWs	14.38	14.38	14.38	14.38	14.38	
	102.98	103.21	83.39	71.99	82.61	
X .9	92.68	92.89	75.05	64.79	74.35	

Table XI - 14

Average Completed Services Per User By Age Group

B.C. Affluent Communities and C U & C Plans

Service/Age	B.C. Affluent Communities				C U & C Plans Plan A - Seventh Yr. Coverage				Plan B First Yr. Coverage			
	0-4	5-9	10-14	15-19	0-4	5-9	10-14	15-18	0-4	5-9	10-14	15-18
1. Emergency Service	0	0	0	0	0	0	0	0.01	0	0	0	0
2. Examinations	0.03	0.11	0.08	0.03	0.51	0.25	0.26	0.22	0.76	0.55	0.54	0.55
3. Models	0.03	0.09	0.31	0.20	0	0	0.01	0	0	0.01	0.01	0.01
4. Radiographs	0.95	1.23	1.60	2.12	0.75	0.95	1.09	1.18	0.73	0.95	1.15	1.34
5. Lab. Tests	0	0	0	0	0.01	0	0.01	0.01	0	0	0	0.01
6. Consult/Report	0	0	0	0	0		0	0	0	0	0	0
7. Maint. Routine	0.97	0.97	1.15	1.35	0.71	0.96	0.94	0.91	0.41	0.58	0.63	0.63
8. Topical Fluoride	0.41	0.50	0.60	0.54	0.73	0.90	0.80	0.62	0.67	0.82	0.74	0.65
9. Hygiene Instruct.	0	0.01	0.02	0.02	0	0	0	0	0	0	0	0
10. Ortho. G.P.	0	0	0	0	0	0.04	0.01	0	0	0.06	0.01	0
11. Extractions	0.03	0.30	0.23	0.10	0.10	0.41	0.26	0.29	0.22	0.68	0.55	0.71
12. Surgery Other	0	0	0.01	0.02	0	0	0	0	0	0	0.01	0.01
13. Scaling/Polish	0.03	0	0.05	0.21	0	0	0.01	0.05	0	0	0.01	0.07
14. Occlusal Adj.	0	0	0	0	0	0	0	0.01	0	0	0	0
15. Perio. Surg. Serv.	0	0	0	0	0	0	0	0	0	0	0	0
16. Periodontal Other	0	0	0	0	0	0	0	0	0	0	0	0
17. Endodontic	0	0.02	0.02	0.03	0.19	0.08	0.08	0.12	0.18	0.17	0.14	0.29
18. Restn. Plastic	1.92	2.43	2.48	2.89	2.30	2.01	2.87	3.51	2.58	3.36	4.13	6.01
19. Restn. Other	0	0.03	0.03	0.11	0.14	0.06	0.06	0.20	0.17	0.11	0.07	0.41
20. Denture Complete	0	0	0	0	0	0	0	0	0	0	0	0.01
21. Denture Partial	0	0	0	0.01	0	0	0	0.01	0	0	0.01	0.03
22. Denture Refit	0	0	0	0	0	0	0	0.01	0	0	0	0.01
23. Denture Misc.	0	0	0	0	0	0	0	0	0	0	0	0
					$114.52		$150.05					
Total Services	170	1939	3191	2991	841	4802	6206	4657	1509	8247	9804	7201
Number of Users	39	341	486	392	154	846	971	651	263	1130	1223	670

Source: 1. CU&C Health Services Society, Vancouver 1972 - 1973.

2. "Demand for Dental Services in Affluent Communities - British Columbia." Department of National Health and Welfare, 1974.

ATTACHMENT #7(c)

Attachment #8

DRAFT OF PARENT NOTIFICATION LETTER

(TO BE DEVELOPED AS PART OF THE COMMUNICATION PLAN - SEE RECOMMENDATION #11)

Date:_____

Student's Name:_____ School:_____

Dear Parent/Guardian:

During a regular dental inspection your child was found to have a dental problem requiring prompt attention.

Your child's health and comfort can be greatly affected by dental disease. Treatment now can reduce future complications and expense.

We urge you to take your child to a dentist to have this condition treated as soon as possible.

Your child may be eligible for special assistance through a Ministry of Health program administered by the health unit. In order to qualify you will be required to meet the following conditions:

- ☐ our family does not have any third party dental coverage (i.e., dental insurance, Family Benefit Allowance, etc.).
- ☐ the costs of dental care for this child will create a financial hardship to the family.

Please check the boxes (✓) if they apply and forward to:
(Dental Division
Health Unit)

If you are not applying for this special assistance, we ask that you leave this form with your dentist when treatment is provided, in order that he/she can return it to our office to indicate that the necessary work has been initiated and our records can be updated.

Should you have any problems locating a dentist or have any other concerns, please contact the Dental Division as soon as possible.

Yours sincerely,

Child's Name: _____

School: _____

Dear Dental Practioner,

On initiation of dental treatment for the above, please sign and return this form to the following address:

Dental Division
Health Unit

Please complete the following:

The above mentioned child has presented him/herself at my office and will be treated by me.

Yours sincerely,

_____ _____

Date Signature

_____

Please print name clearly

Note: PLEASE NOTIFY OUR OFFICE IF THIS CHILD DOES NOT PRESENT HIM/HERSELF FOR COMPLETION OF IMMEDIATE/URGENT CONDITIONS.

DRAFT ONLY

CLAIM FORM

ATTACHMENT #9

PART 1 DENTIST

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION

Costs of dental care for this child are not covered by any form of dental insurance and would be a financial burden to the family.

Parent/Guardian Signature

TOOTH NO. OR AREA	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

TOTAL FEE SUBMITTED

For Health Unit use only

Health Unit Code:

Allowable Amount:

Cheque Number:

Issue Date:

Claim Number:

INSTRUCTIONS FOR CLAIM SUBMISSION

Please forward the completed claim including the parent/guardian signature to the Dental Division of your local Health Unit.

PART 2 — EMPLOYEE/PLAN MEMBER/SUBSCRIBER